AN EXPLORATION OF META-EMOTION AND COMMUNICATIVE BEHAVIOR AMONG PARENTS AND ADOLESCENTS DURING FAMILY THERAPY

by

Andrew Douglas Dohanos

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STATEMENT OF DISSERTATION APPROVAL

The dissertation of **Andrew Douglas Dohanos**

has been approved by the following supervisory committee members:

Sally Planalp	, Chair	**3/26/12** Date Approved
Ann Darling	, Member	**2/16/12** Date Approved
L. Edna Rogers	, Member	**2/28/12** Date Approved
Leonard Hawes	, Member	**2/17/12** Date Approved
Monisha Pasupathi	, Member	**2/28/12** Date Approved

and by **Robert K. Avery** , Chair of the Department of **Communication Studies**

and by Charles A. Wight, Dean of The Graduate School.

ABSTRACT

This dissertation forwards a conceptualization of Meta-Emotion Behavior during the family therapy sessions of adolescent males enrolled in a residential treatment center. Inferences drawn and described in Chapters IV, V and VI were grounded in the participants' communicative behaviors. Fifteen residents and their families were recruited from across four phases of therapeutic intervention. Each family allowed for the audio recording of one session. The resulting transcriptions from each session were subjected to quantitative content analyses and iterative qualitative analyses akin to a Grounded Theoretical approach. The combination of qualitative and quantitative data sets allowed for tracking the range and density of emotion terms and prototypical emotion categories as well as the description of the structural components of differing Meta-Emotion Behavior types. Participants used a wide range of emotion terms (208) to express or discuss an emotional experience. These terms were condensed through content analyses into emotion prototype categories. The categorization of grounded emotion terms allowed for the comparison of participant responses to similar emotion expressions or discussions during the course of their therapy sessions. Consistent with existing literature, responses to emotion could be described as "coaching" or "dismissing." Importantly, the results indicate that coaching type responses include demonstrations of awareness, acceptance, listening and, qualified advice giving. Dismissive responses were characterized by the absence of one or more of these coaching components. The data suggest that parents and therapists were more likely to offer coaching than dismissing Meta-Emotion Behaviors

and that the proportion of coaching and dismissing behaviors did not vary at each stage of intervention. Evidence suggests however that resident Meta-Emotion Behavior was different according to stage of intervention indicating a shift from dismissive to coaching types of responses. Meta-Emotion Behavior emerged as emotion specific among these participants, representing a potentially important conceptual shift in the study of Emotion Regulation Theory. Participant enactments of Meta-Emotion Behavior indicated that coaching often included confrontation, asking questions, and skill focused advice sometimes offered implicitly. Extensions to Emotion Regulation Theory, practical contributions, limitations, and directions for future research are discussed in Chapter VI.

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CHAPTER I

INTRODUCTION

We need only recall our own emotion-filled interactions as adolescents or as parents of adolescents to begin to recognize both the promise and pitfalls of our communicative behavior. Indeed, the way we talk about and respond to the experience of emotion can go a long way toward building or destroying the important bonds between parents and their children. These are the same bonds that extend into and lay the groundwork for adolescents to build healthy relationships to the self and with others in and beyond the family group (Arnett, 1992; Grotevant & Cooper, 1985; Jessor, 1992).[1]

The popular literature and research surrounding emotional intelligence tells us that the costs associated with emotional illiteracy are high (Goleman, 1995; Gottman, Katz & Hooven, 1997; Saarni, 1999). From negotiating the familial crucible, to establishing a vibrant social life, to ascending the organizational ladder, a strong emotional IQ (it is suggested) "greases the wheels." Implicit in these popular and academic writings about emotion, emotion regulation, and emotional intelligence/competence is the idea that we come to learn about appropriate experience and expression of emotion by interacting with our parents. Implicit too, is the sense that

[1] Although they differ on their definition of adolescent "reckless" behavior (an [un]healthy relation to the self) both Arnett and Jessor attend to the importance of parental socialization processes as antecedent conditions.

we seem to reach a relative plateau or at least a point of diminishing returns in our emotional education by the time we reach our adolescent years.

Of course we do not stop interacting with one another during adolescence, nor do we discontinue the experience and expression of emotion. In fact, common conceptions and some empirical evidence suggests that parents and adolescents forge their relationships in a fevered pitch of emotionally-charged communication. In his preface to *Between Parent and Teenager*, Haim Ginott (1969) offers this description of the emotion-filled relationship:

> A day comes in any parent's life when there is a sudden realization: "My child is a child no longer." This is a unique moment of elation and fear. There is joy in seeing our seed – a sapling. There is also apprehension: No longer can we protect him from all winds. No longer can we stand between him and the world, to shield him from life's dangers. From now on he must face unavoidable challenges unaccompanied by us. There is also conflict. As parents, our need is to be needed; as teenagers their need is not to need us. This conflict is real; we experience it daily as we help those we love become independent of us (p. 11).

A central concern in this study is the ongoing nature of what we might call emotional education, not only for adolescents, but also for adult parents. If we take Ginott's conception of the parent-adolescent relationship to be common, normal, and natural, then we begin to see the broad relevance and importance of this kind of investigation. But to me the importance becomes magnified when we consider families who experience these communicative struggles as more than discomfort or inconvenience. For some families (including those who have participated in this investigation), patterns of interaction can produce life-altering or threatening consequences. Among these unlucky families there may be little hope outside of significant professional intervention.

The questions become “How do some families emerge from these interactions relatively unscathed and stable, while others continually suffer considerable detrimental outcomes?” And, more to the point of this investigation, for those troubled families who are able and willing to turn to professional intervention, “In what ways (if at all) are the patterns of emotion communication altered such that there is at least the opportunity for new ways of interacting?”

Theoretical Underpinnings

One framework for approaching these questions is Emotion Regulation Theory which is explicated by the psychologist John M. Gottman and his colleagues Lynn Fainsilber Katz and Carole Hooven (1997). For these researchers “…a point of entry for changing the family system” (p. 34) is understanding the parents’ meta-emotional philosophies, that is, understanding the parents’ emotions about emotion. The idea is similar to meta-cognition or meta-communication in a structural sense. Broadly speaking, the theory suggests that the interaction of parents with their children’s emotional expression is mediated by the parents’ interaction with their own emotion and meta-emotional structure (philosophy). The authors define meta-emotion structure as “…an organized set of feelings and concepts about emotion, and this idea includes the idea of an emotion philosophy” (p. 7). In addition, these researchers have linked alternative philosophies (coaching and/or dismissing described below) with pro- and antisocial child outcomes including quality of peer relationships and academic performance, as well as general health and well-being.

By implication the theorists are pointing to communicative behavior as the manifestation of these philosophies, and yet we know very little about what the enactment of a particular philosophy sounds like in actual conversation, nor, for that matter, has communication been a focus of this area of research. There are some important corollaries associated with this gap in the literature. For example, Ginott reminds us that a part of the tension specific to the parent-adolescent relationship is the (re)negotiation of roles (i.e., the adolescent's gradual movement from subordinate to peer). The tension Ginott describes is in line with other developmental psychology literature that suggests adolescence is a time for individuation, if not separation from parents. This is true for Marcia (1966) who outlines a continuum of ego-identity formation, which revolves around the individual's ability to separate self from parents with regard to ideological decisions. Preferring the term renegotiation to separation, Vartanian (2000) describes the adolescent as an increasingly capable interaction partner prepared to recognize and engage in the interactive struggle between autonomy and connection.

Bringing a communication perspective to this body of scholarship has meant taking a closer look at the mutual (conversational) influence and enactment of both the parent's and the adolescent's meta-emotional philosophy. In addition, whereas the families under investigation in this investigation are among those who have sought out professional intervention, it was equally important, interesting, and beneficial to track the influence of the therapist's communicative behavior. Evidence suggests that the

therapists involved in this investigation worked as a catalyst for changing patterns of interaction.

Meta-Emotion Philosophies and Communication

Consider a description of the behaviors associated with a coaching philosophy: (a) being aware of the child's emotions, (b) recognizing the emotion as an opportunity for intimacy and teaching, (c) listening empathetically and validating the child's feelings, (d) helping the child verbally label emotions, and (e) setting limits while helping the child problem solve (Gottman et al., 1997). Now, contrast those behaviors with a second philosophy described in the literature as dismissing. The dismissing or disapproving parent is, in contrast to the coach, uncomfortable with their child's emotion. Dismissing parents' attempt to distance themselves from their children's experience rather than recognize the opportunity for intimacy, empathy, or coaching. Dismissing parents can be critical of their children and attempt to control or limit the expression of emotion. In addition, the disapproving parent is likely to point out what is wrong with experiencing and/or expressing sadness or anger instead of addressing the emotion itself. In these types of environments, the adolescent is not recognized as an entity capable of understanding, much less an entity capable of negotiating emotional situations. In effect, the dismissing parenting style undermines the development of any positive individuated relation-to-self (i.e., self-confidence, self-respect, and self-esteem) and, ultimately, to the potential development of social, moral, or emotional competence.

This research investigates not only how the adolescent responds to these alternative types of messages from parents, but also to how parents respond to the

adolescent and/or the therapists, who offer "coaching" or "dismissing" messages of their own. When the research focus is ongoing interaction, the behavior of all interactants (parents, adolescents and therapists) is scrutinized and helps to expand our understanding of how emotion regulation is actually accomplished *in situ*.

The questions that drive this investigation address the explanation and control of emotion-laden interactions. At the same time I am interested in the participants' situated enactments and understandings of emotion. That is, I have focused this investigation on the communicative practices which give meaning to the experience and expression of emotion between parents and adolescents. This investigation has helped to identify patterns of emotional interaction which produce and reproduce stagnant positions of opposition, anger, and contempt as well as those that produce movement, negotiation, and satisfaction during family therapy sessions. To put it simply, this investigation has moved closer to answering questions that help to close the theoretical gap between meta-emotional philosophy and the communicative performance of those philosophies.

Meta-Theoretical Considerations

I consider myself a pragmatist (Bochner, Cissna, Garko, Montgomery, & Duck 1991) when it comes to engaging questions of interaction. That is, as Bochner and colleagues have said, "Interpersonal communication becomes a subject that can be described legitimately in several different vocabularies…" (p. 18). Bochner et al. go on to suggest that interpersonal researchers should shift from questions of "Which methods are scientifically acceptable?" to questions that ask "Which methods are best suited to our objectives?" (p. 18). I have adopted what Creswell, Plano-Clark, Guttman and

Hansen (2003) have described as an embedded or nested design. This design has allowed me both to uncover emergent themes pertinent to emotion communication across the family therapy sessions and to identify apparent differences in the emotional profiles of the participants.

Parents, adolescents, researchers and practitioners all stand to benefit from the clarification of the relationship between meta-emotional philosophy and communicative behavior. Again, Ginott reminds us that while the struggles of "healthy" families may differ in scale, they are not altogether different in form and content from the struggles of those families who need help. Researchers in the sister fields of social work, psychology, and communication stand to benefit from the expanded and overlapping look at both parents and adolescents as well as cognition and communication. These overlaps help to address work that is yet to be done in either field. And, practitioners will appreciate the attempt to answer to the practical question; "How does this get done?"

On the other hand, the potential benefits for those more directly involved in the study should not be overlooked or minimized. For the Residential Treatment Center (RTC) involved, there is the ability to name and describe specific methods of intervention or styles of interaction in terms that are easily understood and readily observable. This, of course, extends to the therapists employed at the RTC. We should not underestimate the power in naming/identifying problematic and/or successful patterns. This simple step can, as Gottman and colleagues (1997) have suggested, provide "…a point of entry for changing the family system" (p. 34). This naming process gives the parents and the adolescents a specific problem to solve and a set of communicative skills to hone.

Additionally, exploring the transferability of these skills speaks to the potential ongoing benefits for both current and future resident families of the RTC.

To conclude, let me reiterate my purpose and outline a sketch of the research design. This study addressed the theoretical and operational gap between meta-emotion philosophy and the communicative enactment of those philosophies among parents, adolescents, and therapists. To do so, naturalistic data were collected by recording regularly scheduled family therapy sessions at the participating RTC. The embedded design allowed me to simultaneously identify emotion terms, statements, expressions and discussions within a given therapy session, generate a grounded taxonomy of emotion focused communicative behavior during those episodes, and, finally, to explore the salience of particular emotions for groupings of participants (i.e., families at each phase of intervention). Ultimately, the collection, analysis, and comparison of these data have helped to test, expand, and extend Emotion Regulation Theory as outlined by Gottman and his colleagues.

CHAPTER II

A REVIEW OF THE LITERATURE RELATED TO ADOLESCENT DEVELOPMENT AND EMOTION REGULATION THEORY

Milieu Therapy and Residential Treatment of Adolescents

For Fritz Redl (1959) the power and promise of milieu therapy is its ever-present window into the world of adolescents and children who struggle to manage the demands of their daily lives. More to the point, Redl argues that a milieu approach allows the interventionist to identify specific environmental factors and their affects on the adolescent in the moment of occurance. All of this, of course, implies that the adolescent child is in need of observation and rather extreme intervention. It seems appropriate, therefore, to begin this discussion by offering (1) a description of the characteristics of "struggling teens," (2) insight into the decision to seek intrusive residential treatment, (3) an outline of common but critical facets of milieu therapy, and (4) details regarding the application of particular theoretical orientations for milieu therapy in residential facilities. Later I will move from this broad discussion to a more narrowed focus on these issues as they apply to the residential treatment center (RTC) where this investigation was based.

Struggling Teens

The term "struggling teen" has evolved from variations such as "delinquent," "emotionally disturbed," "troubled," "at risk youths," and many other terms. Reamer and Siegel (2008) argue that "struggling" as opposed to "troubled" for example,

alleviates pejorative connotations and remains descriptive of ongoing behavior rather than labeling the individual. In their own words, the troubled teen label locates the problem "…within the adolescent and is not a result of multiple factors that vary uniquely in each situation, such as fragmented and inadequate services, unresponsive school environments, lack of income supports, racism, homophobia, challenging family circumstances, and mental health issues" (p. 11). Inasmuch as the gerund struggl*ing* implies an indeterminate process rather than stagnate, determined or finite state, I agree with and will adopt Reamer and Siegel's usage throughout this document.

This shift in terminology draws attention to some important conceptual themes (e.g., change, adaptation, and agency), each of which will reoccur throughout this review and ultimately play a role in the rationale for this investigation. For help on these issues, I turn to Lewis (1997) who argued that individuals do not simply engage in a linear progression from birth to death. The past does not *determine* the future. Rather, according to Lewis, human beings are forced to adapt both in the moment and with the context. Shifting contexts bring with them inherently contradictory interactions and as such foster shifting engagements with the world. In turn, engaged contradiction fosters change and/or adaptation. For Lewis, adherence to a deterministic model of child development into adolescence depicts "…passive human beings closed by their past and restricted in their future" (p. 51). Indeed, determined futures allow for no choice and no recourse.

For Lewis, the discontinuity in life, the reality of agency and the possibility of adaptation provide the opportunity for intervention, therapy, and hopeful futures. For these authors and for those who work with struggling teens, the term *struggling* broadly refers to the adolescent's ongoing attempts to meet emotional, behavioral and/or

academic challenges in given situations. Often in the interaction between the individual and his or her environment/milieu, these struggles manifest themselves as maladaptive behaviors (Newcomer & Ashton, 1993). To provide additional context, I will briefly address some of the common maladaptive environmental responses that lead families to seek professional help, including residential treatment when the cases are severe.

Symptoms of Struggle

Reamer and Siegel (2008) provide a strong review of symptomatic behaviors prevalent among struggling teens. It is important to note that the degree of severity, presence or absence of particular symptoms (and combinations of symptoms) as well as the appropriate level of response will vary from case to case. The categories addressed below are by no means an exhaustive list, nor are these categories meant to be seen as mutually exclusive. Often parents and teens will report multiple and overlapping behaviors as the source of their concern and the impetus for seeking intervention. This is true for the industry at large as well as the RTC involved in this investigation.

The first of the behaviors reviewed is isolation and/or withdrawal. The adolescent tendency towards independence (particularly from parents) is not in itself a problematic behavior. In fact, as the Ginott quote from the introduction of this document suggests, this kind of behavior is a normal and necessary part of development. I will address the idiosyncrasies of adolescence in more detail below. For now it should be sufficient to say that the situated needs of adolescents have a strong bearing on their behavior (communicative and otherwise). Carried to extremes, isolation can have a negative impact on the adolescent's sense of self. It can become difficult for the adolescent to

build and maintain important peer and familial relationships, and the acquisition of basic interactive skills and role-identity development are at risk (McCall & Simmons, 1978).

Reamer and Siegel also report that struggling teens often have limited academic success. Reasons for academic struggles vary, of course, but can include limited access to support in the home and/or the school. Others who have (un)diagnosed learning disabilities may or may not receive adequate attention and/or accommodation. In my experience with adolescents at the RTC involved in this investigation, academic success or failure can become an issue of lower priority when contrasted with other more pressing/dangerous maladaptive behaviors. That is to say, academic achievement may be more inconsistently rewarded than, for example, milestones of sobriety or advances in relation to self so that suicidal ideation subsides. In this way academic performance can be impacted negatively by a stronger focus on more pressing issues. Importantly, I have also observed adolescents whose commitment to and achievement of academic successes serve to hide (from parents) or distract (themselves) from "deficiencies" in other areas.

Acts of independence including defiance of authority and running away from home are also common behaviors for struggling teens. These acts can take the form of drug use, stealing, sexual activity, reckless driving, etc. Of course many of these acts lead to consequences enforced by law. Others of these acts are left to be settled between the parent and the adolescent. In many ways this returns the discussion to the negotiation of autonomy and connection. Where adolescents openly and actively defy authorities, they are engaging in behaviors that assert their independence, demand recognition (or at least response), and test the limits of their personal autonomy. Jessor (1992) argues "[T]here is nothing perverse, irrational, or psychopathological about such goals. Rather they are

characteristic of ordinary psychosocial development, and their centrality helps to explain why risk behaviors that serve such functions are so intractable to change" (p. 378).

Although the risk behaviors that adolescents take part in may be acted out impulsively, Jessor suggests that the assumption that adolescents are simply thrill seeking as they engage in these kinds of behaviors is naive. "Few adolescents continue cigarette smoking for the thrill of seeing whether they can avoid pulmonary disease…" (p. 379). Instead he suggests that these are steps towards renegotiating their social and familial positions. That this renegotiation of connection-autonomy is a work in progress is evidenced by behaviors like running away from home only to establish relationships with other teens who find themselves in similar situations. Fleeing from distressed homes and the avoidance of the difficult emotions associated with family conflict (sometimes brought about, but at least exacerbated by, the adolescent's behavior) highlights the incompleteness of their transition to individuation.

Depression, alcohol and/or drug abuse, eating disorders, and self-harm are symptomatic behaviors that can be difficult to address, understand, or even recognize. These behaviors are often subversive. Often, maladaptive behaviors are purposely hidden by adolescents from their parents (Mazur & Hubbard, 2004). In other cases, these difficult topics can be avoided or missed by frightened or unaware parents (Reamer & Siegel, 2008). The compulsive and addictive qualities of chemical dependency, eating disorders, and self-harming are, even if recognized, difficult to overcome without professional help. When depression leads to feelings of worthlessness or hopelessness, suicidal ideation can become salient for some teens.

Eating disorders and self-harming behavior can be particularly difficult for parents to understand. Reamer and Siegal (2008) list "…cutting, burning, branding, bruising, and hitting…" (p. 16) as common forms of self-harm. The authors suggest that general consensus among mental health professionals is that self-harm is adopted as a coping mechanism that provides temporary relief from difficult emotions. In my own discussions with adolescents who engage in these behaviors, control has been a re-occurring theme. A sensation of release from emotional pain or, on the other hand, the sensation of emotion itself is perceived to be utterly under the control of the individual. Ironically, however, the behavior can become addictive or compulsive and, therefore, difficult to control. Similarly, eating disorders in the form of anorexia nervosa and bulimia are compulsive behaviors symptomatic of adolescents' struggle to fit with the given circumstances of their environs. These behaviors too can be difficult for parents to spot and/or understand.

The relative presence or absence of the above symptoms often lead bewildered parents to have their children assessed by mental health professionals. In their 2008 review, Reamer and Siegel reported the most common psychiatric diagnoses among struggling teens. The results include: a) anxiety disorders (i.e., panic disorder, obsessive-compulsive disorder, and posttraumatic stress disorder), b) major depression, c) bipolar disorder (i.e., swings between states of mania and depression), d) attention-deficit/hyperactivity disorder (ADHD), e) conduct disorder (i.e., the violent and destructive violation of others basic rights), f) oppositional defiant disorder (i.e., an ongoing pattern of hostile behavior towards authority), g) eating disorders, and h) substance abuse and dependence. Obviously, the range and severity of symptoms as well

as the possible diagnosis of a particular psychiatric disorder provide parents and the professionals they enlist for help with the information necessary to select the appropriate form of intervention. Having offered a synoptic description of the *struggling* teen, I will now turn the discussion towards the process of selecting an intervention.

The Historical Context of Intervention

Discussion regarding how to handle delinquent, disturbed, troubled, or struggling youths as separate and distinct from adults has a long tradition. Reamer and Siegel (2008), for example, quote John Stuart Mill's exception to the rule on his assertions of liberty,

> We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury. (Mill, 1859/2008, p. 6)

Mill's tone is reflected in what Reamer and Siegel refer to as the era of child saving (this might more precisely be defined as the first half of the 20th century). The child saving era, as they describe it, is one where the *troubled* adolescent is seen as the victim of circumstance, not to be held fully accountable for misbehavior. This worldview held sway until the 1960s when "[T]he remarkable intersection of social and cultural trends…provided fertile conditions for the nascent struggling-teen industry" (p. 10). According to Reamer and Siegel, increased demands for accountability, the emergence of calls for diversion and deinstitutionalization of teens,[2] as well as the push for new and

[2] Diversion refers to the attempt to keep children out of the hands of the law often by means of mentoring, counseling, vocational training, alternative education programs or residential treatment. Deinstitutionalization refers more specifically to those with mental illness in psychiatric hospitals and

innovative forms of community-based programming,[3] gave birth to the struggling teen industry as we know it today.

The Least Disruptive but Most Effective Setting

Wilson and Lyman (1983) outlined four principles to guide decisions for enlisting any method of intervention. Chief among those principles are the check and balance of the least disruptive setting (this sentiment falls in line with the call for deinstitutionalization) against the most effective intervention. Here, families are weighing the potential for therapeutic effectiveness against the potential for disruption of the natural environment. Community-based programming, outpatient treatment, day treatments, and respite care provide examples of intervention models that range from in-home visits to short term removal from the home (i.e., up to 3 weeks), respectively. In some cases, these relatively short and unobtrusive interventions allow for the necessary adaptations and generalizable therapeutic effects. For others, more long-term interventions are necessary. Foster care and group homes include the removal of the child from his or her home for extended periods of time (potentially years). Great pains, however, are taken under these models to produce a typical "homelike" atmosphere including the role of foster parents.

Residential Treatment Models

Still further along the continuum of relative intrusiveness there is residential treatment. DeSisto and Koltz (1985) argue in favor of residential treatment for

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inmates in correctional facilities. It is linked with diversion in that the goal is to avoid institutional care of adolescents were possible.

[3] Community-based programs limit the intrusiveness of intervention. Programs take the form of home-based crisis intervention, specialty courts, alternative high schools, etc.

adolescents when parents "…no longer feel capable, on their own, of taking care of their child, or of providing the nurturing and the role modeling the child needs…" or "…they feel helpless in setting up and enforcing limits on the child" (p. 130). Whereas the foster and group home models resemble typical family structures, residential treatment facilities put less effort into producing an environment similar to one the child might consider "natural."

Lyman, Prentice-Dunn, Wilson, and Taylor (1989) describe residential treatment as isolated from the general public and programmatic in the sense that these facilities are guided by and follow one of several well-defined treatment philosophies. Residents in these facilities must receive a diagnosis of a mental disorder. Most commonly the diagnoses fall within the range of the disorders discussed above. According to Reamer and Siegel (2008), it is the increased severity and persistence of their symptoms that distinguishes candidates for residential treatment from those who might be more appropriately placed in other less disruptive settings. These relative outliers among the population of struggling teens are those whom this investigation is concerned with.

DeSisto and Koltz (1985) also acknowledge that the decision to enroll their children/adolescents in a residential treatment program is not an easy one for parents. Often these parents are dealing with feelings of failure, guilt, and loss. Ultimately it is by a process of elimination (i.e., having exhausted other options) that the parents choose residential treatment. Having decided to seek this form of intervention, the question becomes what type of residential program is most appropriate? Wilson and Lyman's (1983) third principle for intervention selection, particularly the intrusive practice of residential treatment, provides some guidance. "…[A] child's clinical condition and

behavior should be matched to the philosophy, structure, and capabilities of the treatment environment" (p. 8).

The literature implores parents to develop an understanding of the basic philosophy guiding the various treatment/intervention options so that they may maximally meet their child's needs. The risks to the child involved in an inappropriate placement are somewhat intuitive (e.g., unavailable or inadequate resources, limited therapeutic progress, stifled development of independence, diminished likelihood of generalized skill building). What may be less apparent, however, is the toll exacted on the peripheral actors involved in the intervention. Inappropriately placed patients can become a drain on the time, resources, and patience of their staff, not to mention their peers who are also in need of a stable therapeutic environment (Lyman et al., 1989). Under or overly restrictive interventions can limit the effectiveness for all those involved in the process (i.e., parents, children, and staff).

Adding to the difficulty in selecting the correct treatment facility is the interpretation of important and often overlapping clinical terms (e.g., milieu therapy and residential treatment). Brendtro and Wasmund (1989) attempt to demystify the term "milieu therapy" by suggesting simply, "[m]ilieu therapy is a generic concept covering the myriad of ways in which the dynamics of a residential environment can be planfully used in the treatment process" (p. 82). As this definition implies, there are several possibilities for residential programs. To explore the most common philosophical models and their applicability to this investigation I return to the review provided by Lyman et al. (1989).

Each model offers distinctive strengths and is, therefore, differentially appropriate for individual cases. The same can be said regarding each model's relative appropriateness for the focus of this research project (i.e., addressing the theoretical and operational gap between meta-emotion philosophy and the communicative enactment of those philosophies among parents and adolescents). The psychoanalytical model (Bettelheim, 1950), as the name suggests, foregrounds the importance of individualized and, to a lesser extent, group psychoanalysis. Under this model, it is assumed that the largest strides toward therapeutic recovery are made during formal "sessions" with the professional staff. Although under this model, adolescents often discuss significant emotional issues/disorders, they do so in relative isolation from their parents. This would leave little room for this investigation's focus on accessing the interaction sequences that involve both parents and their children. Speaking practically, the psychoanalytical model has not been among the commonly used forms of residential treatment since the 1960's (Lyman, et al., 1989) when behavioral models became more popular.

The behavioral model, based in learning theory (Rotter, 1954), assumes that human behavior is influenced by the value placed on an outcome and that expected (i.e., learned) outcomes are dependent upon particular behaviors. Given its basis in learning theory, the behavioral model tends to focus primarily on overt actions as opposed to exploring internal states. The catalyst for changing maladaptive behaviors under this model is the implementation of positive and negative reinforcements in response to positive and negative behaviors, respectively. Under this model the relative importance of direct care workers is championed because of their access to the patient in the moment of behaving. The behavioral model, in its basic form, maintains a focus on an individual's

actions, not necessarily in relation to the family system. This, of course, limits the applicability of these types of residential facilities to this research.

A variant of the behavioral approach is the psycho-educational model, which allows for the continued interaction of the resident patient with his/her family where possible (Lyman et al., 1989). Although facilities that employ the psycho-educational model might provide access to the interactions of parents and adolescent residents, the model remains focused on behavior to the exclusion of exploring the psychological underpinnings of the behavior. In describing the principles of Re-Education programs, Hobbs (1982) reinforced that claim when he argued that individual symptoms of maladaptive behavior can be controlled without delving into psychodynamic work. The focus of this investigation is not exclusively on behavior, but on emotion and cognition as well.

Two other philosophical models for residential treatment deserve to be mentioned before describing in detail the model most conducive to the work being proposed. The first of those models is the medical inpatient approach. Perhaps the oldest of the models discussed, medical inpatient facilities are equipped to offer support to patients in need of acute psychiatric diagnoses and/or medical treatment. This type of intervention is described by Lyman and colleagues as "limited" in duration and increasingly focused on the "…periodic hospitalization of clinically mentally ill children and adolescents…for the purpose of providing respite and stabilization" (p. 10). In cases where suicidal ideation has turned to the manifestation of suicidal behavior, adolescents from the RTC under study have been temporarily transferred to the care of medical inpatient facilities for "respite and stabilization" before returning. In other cases, newly admitted residents may

have come directly from an acute care facility. Obviously, this form of residential treatment does not lend itself to the purposes of this investigation given its specific attention to very basic forms of personal safety.

More often, residents of the RTC under investigation are admitted not from medical inpatient facilities but after having spent time in a wilderness therapy program. Reamer and Siegel (2008) describe wilderness programs as a place where struggling teens have " … the opportunity to develop self-confidence by mastering outdoor challenges, such as starting a fire without matches or a lighter, that require persistence, patience, frustration tolerance, and skill" (p. 32). Among the primary benefits of these programs is the ability to closely observe the adolescents in an effort to better diagnose their particular issues, the opportunity for the adolescent to reflexively identify and understand their issues for themselves, and the opportunity for the adolescents to develop new "adaptive" patterns of behavior (Lyman et al., 1989). Contact between parents and adolescents in these programs is limited and, therefore, limits the utility of the model for this research.

The Positive Peer Model of Milieu Therapy

The positive peer culture model (PPC), is described by Vorath and Brendtro (1985)[4] as a derivative and practice based methodology. Among the factors of relative success addressed by the PPC model is attention to the continued development and maintenance of familial relationships for the resident adolescent. The authors argue that "[d]espite abundant pro-family rhetoric, many residential programs have long histories of

[4] Vorath and Brendtro note that PPC draws on but diverges from Vorath's experience with the development of another peer-oriented model, Guided Group Interaction (GGI), under the direction of Lloyd McCorkle in the late 1950s.

minimizing contact between a youth and his family" (p. 134). Seigal and Reamer's (2008) more recent review suggests that trend has held. For Vorath and Brendtro, the issue of family involvement stands as one of the primary determinants of success or failure both during an intervention and after the resident's release and re-introduction to the family system. To the extent families are incorporated as partners in the intervention process, the likelihood of generalizing their newly learned skills to their natural environment is increased.

The expressed commitment of the PPC model to continued contact between adolescent residents and their family immediately foregrounds its applicability to this investigation's focus on adolescent-parent interaction. In what follows, I will outline several other PPC guiding principles that are particularly applicable to the exploration of Emotion Regulation Theory (i.e., emotion coaching and/or dismissing among the residents and parents).

Redl (1959) argues, that a "good" or strong milieu depends on, among other things, the needs and idiosyncrasies of the potential resident patient. For example, the PPC model of milieu therapy is aimed at harnessing the power of adolescent peer groups. Teens, as opposed to younger children (i.e., 12 and under), begin to seek out their peers rather than their parents as confidants (Arnett, 1992; Jessor, 1992; Vorath & Brendtro, 1985). The recognition of this tendency and of the potential power in "peer pressure" for good rather than ill is the foundation of this models approach (Vorrath & Brendtro, 1985).

Researchers have shown that enrollment in peer-oriented programs is linked with various prosocial outcomes. Wasmund and Brannon (1987) for example, link increases in

positive self-concept with increased interpersonal competence – an adaptation to the social demands of the context. Wasmund (1988) also found that in comparison with non-peer group models, members of peer group programs report greater satisfaction with their environment, felt more supported, involved, and willing to express emotion freely. One caution highlighted by the research, however, suggests that the productive development of a PPC and the general acceptance of the program by its residents is dependent on the peers' relative sense of autonomy/participation (Osgood, Gruber, Archer & Newcomb, 1985). That is, in adult-dominated, control-oriented programs the resident population often forms a counter-control culture, in resistance to the program and those who seek to implement it.

The subtle difference between guiding and controlling the peer group's interaction is an important point. In fact, as will be discussed later in this review, it relates quite closely to the difference between emotion coaching and dismissing philosophies outlined by Gottman et al. (1997). For now, it should be noted that among the basic assumptions of the PPC model is that a considerable amount of agency is granted to the adolescent residents. It might be helpful to begin to think of the peer group as the "builders" of their culture and the adult staff employed by the RTC as the "building inspectors." As "inspectors" the adult staff enforce limits and provide normalized guidelines for behavior but leave individual decisions for acting within those guidelines to the residents themselves.

Devoting attention to the interaction of the peer group is in line with another of Redl's (1959) assertions about milieu therapy, namely, that social structure is among the most important variables in a given environment. More important than simply identifying

the social structure is answering the question; "How does social structure affect therapeutic intervention?" For this investigation, answering this question will not only provide a better understanding of the positive peer culture (PPC) model, but also open the door to a discussion of this model's use in the RTC involved in this research.

PPC, Social Structure, and Therapeutic Goals

Chief among the therapeutic goals of the PPC model is the empowerment of the individual adolescent resident and, by extension, empowerment of the group (Vorath & Bredtro, 1985). This sentiment is made explicit when the authors suggest that "[y]outh need opportunities to experience difficulties and surmount problems in order to learn how to cope effectively with the vicissitudes of life…" (p. 12). This statement brings to the foreground the idea that to empower the resident "youth," they must first be recognized as legitimate and capable decision makers, worthy conversational partners, and adaptable to the demands of social interaction.

To provide these "opportunities," the PPC model rests on several interdependent assumptions. First, the PPC depends on a climate of trust and openness rather than on invasion and exposure.

> In contrast to traditional treatment approaches, PPC does not ask whether a person wants to receive help but whether he is willing to give help. As the person gives and becomes of value to others, he increases his own feelings of worthiness and builds a positive self-concept. (Vorath & Brendtro, 1985, p.xxi)

The model assumes that attempts at coercing peers to emotionally expose themselves with the goal of catharsis will likely invite responses of defensiveness, fear, and/or anger. Rather, demonstrations of concern and modeling of openness from others might elicit

from the skeptical resident the foundations for trust and a willingness to reciprocate similar levels of openness. Although initially this first assumption may seem to indicate an overly protective environment where a resident might effectively manipulate the group away from his/her issues, the second assumption of the PPC model works to assure this does not happen.

The PPC model works in a climate geared toward change rather than security. Antisocial and self-destructive behaviors are named, challenged, and associated with the natural social consequences of enacting unaccepted behavior within the group (i.e., positive peer pressure). The goal here is to enhance the residents' emotional response to their maladaptive behavior. "PPC does not promise a young person a world of contentment, security, and freedom from anxiety; rather, a climate is created where all behavior that hurts another person is noticed and challenged" (Vorath & Brendtro, 1985, p. 13). The authors suggest that the constant negotiation of these first two assumptions (i.e., trust/openness and change) provide the model with its greatest point of leverage: raising awareness of the behavior and its consequences in the moment of action. This points to the third assumption of the PPC model.

Staff and residents alike are encouraged by the third PPC assumption to remain focused on the immediate as opposed to the distal problems of the resident. The model asks residents to account for "…their own behavior and feelings in the current real-life situation" (p. 14). Recall that for Redl (1959), the power of milieu therapy is in being present in the moment when emotion, distress, anxiety, issues or problems arise. The interventionist's presence offers a unique perspective and opportunity for teaching. The attention devoted to addressing the issue in the moment presents an opportunity for staff

and/or peers to coach one another towards appropriate responses. And, as each issue is addressed, the residents can begin to build or adapt their repertoire for future similar interactions. Problems, then, become opportunities rather than troubling setbacks.

This final assumption brings this discussion full circle. To reach the goals of empowering the resident and the group, they must be presented with the opportunity to overcome adversity. Vorath and Brendtro (1985) refer to the writings of the anthropologist Benedict (1938) in the introduction of their review of PPC, their comment seems appropriate here. The authors note that Benedict was right when he observed; "…contemporary society does not provide meaningful role opportunities for youth; rather, it prevents them from assuming adult responsibilities and then blames youth for their irresponsibility and belligerence" (p. xi).

This view recalls the idea that the adolescent enrolled in an RTC must be recognized as someone capable of having and solving problems as they occur naturally. Again, the PPC works within a climate of change rather than within the security of stability. Staff and residents are encouraged to accept that problems are a normal part of daily life, that acknowledging that one has a problem is a sign of strength, that once a problem has been identified it can be addressed, and finally, that the problem of any individual is an opportunity for the group to help.

In essence, the PPC model is a problem-solving model based on utilizing the advantage of adapting to lived experience in ways that meet with group expectations for appropriate behavior. The model grants the agency of decision making to the adolescent within the boundaries and guidance of adult supervision. Above all else, the model seizes situated interactions as moments for teaching or coaching socially appropriate behavior.

Whereas these basic assumptions describe the PPC model in general, I will now describe the specific applications of the PPC model in the RTC proposed for this investigation (hereafter simply referred to as the RTC).

The Residental Treatment Center

I conducted this research at an RTC where I was employed as a milieu manager between October, 2005 and April, 2010. The RTC is located in the intermountain west. The expressed goal of the organization is to provide a therapeutic community wherein adolescents can "…develop self-worth, significance, dignity, and responsibility…" (Balmer, 2005, p. 2). To that end, the organization embraces the principles of a PPC model of milieu therapy (Vorath & Brendtro, 1985). As it is described above, the PPC model rests on the manipulation of adolescent peer group interaction.[5]

More specifically the model, as employed by the RTC, focuses attention on the interdependence of the individual, his/her relational partners, and their collective environment in an effort to facilitate the development of both social and emotional competence. Residents and staff of the RTC often engage in moments of "processing" where the focus is on immediate situation-specific (emotion eliciting) events. Processing occurs in real time and allows the resident to experience, understand, and work with their emotions. In its attention to live action and the opportunistic teaching of problem solving skills, processing is similar in form to Redl's Life Space Interviews outlined by Newcomer and Ashton (1993).

[5] I have come to interpret "manipulation" to mean the direction of daily activities toward the institutionally sanctioned ends of: a sense of membership, a sense of physical and emotional security, a sense of social responsibility, and a sense that personal contributions to the community are both valued and influential.

A second and related component of the RTC program helps to highlight the centrality of developing adaptive problem solving skills and ultimately, the applicability of those skills to the interactions of the adolescent resident with his/her parents during family therapy sessions. Positive Peer Groups (PPGs) conducted three times weekly at the RTC are small group interactions run by residents that are designed to allow one member of the group to seek advice from peers regarding the resolution and/or management of a range of emotion-laden issues. The "processing" techniques described above are utilized in these groups with only subtle and distanced guidance from "staff" or other adult authoritative figures (i.e., therapists). The interactions in these groups invite the expression and regulation of emotion and, as such, provide a particularly clear look at how deeply engrained skill building and testing are in the RTC's basic philosophy. In what follows I provide a detailed account of the PPG process to describe how the groups follow the assumptions of the PPC model discussed above. The process as described below and implemented by the RTC staff follows the protocol for the group outlined by Vorath and Brendtro (1985).

The Positive Peer Group

As I attempt to describe the importance of the PPG, I am reminded of the old proverb "give a person a fish and you feed them for a day, teach a person to fish and they may feed themselves for a lifetime." Balmer's (2005) RTC Employee Handbook helps to clarify my point in describing its community as:

> …an environment, a forum, where newly learned, pro-social, behavior can be "field-tested" in an atmosphere that is supportive and not only by staff but by fellow residents. Thus, each resident is provided with the

> opportunity of practicing and integrating a new repertoire of behaviors and life skills, different from their historically maladaptive ones. (p. 2)

The PPG provides a particularly important forum within this community for the "field-testing" of their empathic capacity and problem solving skills. From the physical setup of this particular group to the structure of the group process through the actual enactment of those processes, the adolescent residents of the RTC are guided to coach one another through their individual issues. In so doing, the residents are becoming both the "fisherman," engaged in competent behaviors and the "teacher," coaching others using their new skills. Throughout this review of the PPG, I will refer briefly to particular skills of emotional competence (Saarni, 1999) where appropriate. A more thorough review of those skills will be addressed later.

Group Description and Physical Setup

Described in the RTC *Standard Operating Procedure Guide* (2005) (SOP), as "PEER RUN" (p. 1), the underlying tone and explicit purpose of the PPG is to provide the adolescent residents a sense of ownership of the group. Indeed, repeatedly in the SOP, the author reminds the reader that the role of the houseparent[6] (referred to above as "milieu manager") is to "…learn the subtle process of influencing the group without controlling it" (p. 1). There is a delicate balance at play here where the houseparent, who as the name implies stands in as a representation of the adolescents' actual parents, takes on the role of an important but increasingly distanced (physically, psychologically, communicatively) influence. Rather than offering authoritarian guidance, the "parental" influence here is as facilitator of the adolescent's agency and autonomy as a decision

[6] The houseparent or milieu manager acts as the adult authoritative figure within the system. The houseparent lives among the residents acting essentially as a mother or father figure.

maker/problem solver within culturally defined appropriate, stable, and predictable limits. Ideally, the houseparent provides an environment conducive to the individual's ability to seek out and incorporate appropriate methods for adapting to the particular circumstances of a given interaction.

Interestingly, one of the realizations facilitated by this group process is that often autonomous acts are carefully balanced with our connection to others. In many cases the appropriate regulatory response and evidence of individual adaptation (evidence of self – efficacy) may be in recognizing when it is appropriate to ask others for help or advice. Implicitly, each time a resident requests time in the PPG group, he or she is asking for help. The question becomes whether the resident can clearly articulate his or her specific needs. The following exchange exemplifies the clarification of roles (i.e., advice seekers and advice givers) and reinforces the general purpose (adaptive problem solving) within the group.

> Rather quickly (after four votes) the group reaches consensus. The PPG goes to LG.
>
> LG begins by talking about her adopted parents and discloses that her birth mother has recently attempted to establish contact with her through the adopted parents. LG also says that the adopted parents have been in contact with LG's IV therapist about this.
>
> LG's birth mother sent a letter to the adopted parents; they in turn sent the letter to the therapist, and LG recently read the letter herself. The birth mother has expressed her interest in meeting LG.
>
> LG also suggests that she has been angry about the amount of talking her IV therapist and her adopted parents have been doing without her, about this issue.
>
> In the midst of LG's story, C interrupts to ask, " what do you want to get out of this group?"

LG responds with “Some ideas about how to deal.” (Fieldnotes, 10/27/07)

The purpose of the group is reinforced by its physical setup which provides a symbolic model for the interplay of autonomy and connection in the adolescent’s movement within and between the family unit and the peer group. Forming a circle with their chairs, the peer group leaves one space open for the houseparent. The houseparent places his or her chair neither into the space far enough to fill it, nor out of the space far enough to be completely excluded from the circle. Here the adolescent is not outside the boundaries of the parents influence nor is she overly constrained by that influence. The peer group is offered the opportunity to act autonomously under the distanced supervision of the acting “parent” figure. The presence of the houseparent helps to ensure the “testing ground” is safe and supportive so that the participating residents are willing to be open and honest about their problems.

Reporting of Problems

The first phase in the group process is the reporting of problems. The immediate point to be made here is that the moniker “reporting of problems” denotes the general purpose (problem solving) and available roles (advice seekers and givers) for the members of the group. In this phase residents are asked to report from a list of “vernaculars” (see Table 1) what they “…have been working on since their last PPG.” According to the RTC Employee Handbook, the vernaculars simplify the “…often complex psychiatric or psychological jargon into a “user friendly”, easily understood, universal language of problems which aids in therapeutic interaction amongst peers” (Balmer, 2005, p. 2).

Table 1*Vernacular Descriptions and PPG Reporting Examples*

RTC Vernacular	Description	PPG Reporting Examples "I have been working on …"
Authority Problems	Does not want to be managed by anyone.	"Authority problems by thanking staff for their feedback"
Misleads Others	Draws others into negative behavior.	"Not misleading others, by only giving advice during groups, never one on one"
Easily Mislead	Is drawn into negative behavior.	"Not being mislead by being assertive when I know something is not right"
Aggravates Others	Treats people in negative, hostile ways.	"Not aggravating others by processing with the people I usually bother"
Easily Angered	Is often irritated or provoked or has tantrums.	"Anger problems by taking time away from the group when I start to feel angry"
Stealing	Takes things that belong to others.	"Stealing issues by writing in my journal when I think about it"
Alcohol/ Drug Problems (CD)	Misuses substances that could hurt self.	"CD issues by completing [AA] step three"
Lying	Cannot be trusted to tell the truth.	"Not lying by holding myself accountable with staff, each time I lie"
Fronting	Puts on an act as opposed to being real.	"Not fronting by asking my peers to hold me accountable when they see it"

I liken this process of reporting to Saarni's (1999) third skill of emotional competence "…the ability to use the vocabulary of emotion and expression terms commonly available in one's (sub)culture and at more mature levels to acquire cultural scripts that link emotion with social roles" (p. 5). Although the vernaculars do not represent emotions in and of themselves, they do represent emotion-eliciting issues or problems in that the adolescent's (in)ability to navigate the problem often brings about anger, sadness, frustration, or happiness, pride, and satisfaction given their level of success. In many cases, the problems represent maladaptive coping mechanisms (stealing, fronting, CD, etc.) so that solving the problem means teaching and learning new emotion regulation techniques.

More directly, this process is evidence of the mobilization of the group around the task of problem solving. The ability to name and have a shared understanding of particular problems by one member of the group provides an opportunity for others to empathize or sympathize (Saarni's skill 6) depending on their past experiences. In this way, the naming of specific problems implies the need to fulfill specific social roles. The recognition and enactment of these roles is evidence of the ability to discern others' emotional state (skill 2) and a level of relational awareness (skill 7). In addition, the act of naming problems and the ensuing discussion of the associated emotional experience of those problems can aid at the simplest level, in raising both individual and collective levels of emotional awareness (skill 1). As can be seen, attention to one skill can have significant if indirect implications for several others. Coaching or teaching at this level seems more implicit in the basic structure of the group than explicitly enacted in the

communicative behavior of the group members. This is true of the next phase in the group process as well.

Awarding the Group

This second phase unfolds in a step-by-step process. First, each member of the group is permitted to request that the group focus on him or her (a demonstration that the resident recognizes his/her peers as a valuable resource for coping with problems). The resident requesting time is asked to clarify for the group what he or she would like to talk about. Once everyone is aware of who would like the group's time, the nomination or "voting" process can begin. Residents are permitted to nominate anyone they would like, including those who did not request time. This process continues until the group reaches consensus regarding the nomination. According to the PPG SOP, a well functioning and cohesive group will reach consensus relatively quickly, whereas a dysfunctional group may not reach consensus in the allotted time. The SOP offers insight into the logic behind forcing consensus. The SOP suggests that when groups "bog down," it can be a good "diagnostic tool… allowing patterns to emerge" (p. 2). In addition, the SOP warns against solving the problem for the group.

Intervention from the houseparent at this point would immediately squash any sense of ownership or autonomy for the peer group, thus reinforcing the idea that they cannot or should not make decisions for themselves. Such an intervention would reflect Gottman and colleagues' (1997) dismissive parenting style. In effect, allowing the group to flounder suggests that it is okay to become frustrated. Perhaps more importantly, with the frustration comes an opportunity to practice regulatory and coping skills. This

willingness to let the residents remain "in" the emotion is reflective of a coaching meta-emotional philosophy (Gottman, Katz, & Hooven, 1997), as will be described in greater detail below. For the cohesive group, coaching remains at an implicit level and the houseparent's role remains limited. For the dysfunctional group, however, struggling to reach the *problem solving* phase makes it important that the houseparent provide guidance during the *Summary,* discussed below. I turn next to the heart of the group.

Problem Solving

The problem solving phase *is* the "testing ground" described by Balmer (2005) in the Employee Handbook. It is here that the residents display their levels of emotional (in)competence in their ability to coach one another through the process of solving their problem. Having reached a consensus, the group member who is awarded the time will often begin with a brief narrative description of the particular events leading up to continued or renewed use of his or her old problematic behaviors including maladaptive emotion regulation techniques. The character of coaching or teaching in interaction (as opposed to the coaching implicated in the structure of the group described above) can be somewhat subtle. In observations of the group, I found that advice was often offered in the form of questions rather than in directive statements.

In addition, observations of these interactions have revealed that coaching behaviors might be aimed at individual skill deficits. The example provided below records a well-placed intervention from a houseparent. It is important to take note, first, of the structure of the intervention. The houseparent asks for clarification of the resident's narrative, demonstrating a willingness to understand the story from the adolescent's

perspective. Only then does the houseparent begin to offer advice and only in the form of questions. This format reflects what Ginott (1969) called the new code of communication. Here, expressions of understanding precede attempts to offer advice, and this, as will be described in more detail below, is the foundation of what Gottman and his colleagues (1997) have called coaching.

> At this point CO interjects: he tries to recount the details of A's story, asking for confirmations along the way "Is that right"? He then offers some guidance in the form of questions. "Here are some things I think you should think about: "What does your adopted mother think about the situation?" "What does she think you should do?" "What do you want from your birth mom?" "Are you prepared for the answers you might get from your mom and birth mom?." (Fieldnote, 1/5/08)

This excerpt from field notes offers a glimpse at how the resident peers are coached to coach. In these brief utterances, the houseparent has accomplished a number of important tasks. First, he has at the relational level of the message conveyed to A and the onlooking peers that he wishes to understand A's position. Next, the houseparent asks questions that are guiding but ultimately engaged at A's discretion; the agency remains with A. Questions asked in these contexts might be viewed as miniature models of Ginott's new code of communication. That is, because the utterance of a question leaves the defining answer or "understanding" to the respondent. The question does not presume absolute or authoritarian direction. Although the questions are directed to A, the resident peers remain as indirect recipients of the process. In this sense, the houseparent acts as a model/coach or social referent for the group as a whole. Depending on the length and quality of the reporting and awarding phases, the problem solving phase of the PPG is typically 45-50 minutes long. The final 10-15 minutes of the group are reserved for the houseparent to provide a summary of the process.

The Houseparent Summary

Limiting the houseparent's most active role in the group process to the final 10-15 minutes again underscores the residents' ownership of the group. Its structural placement also seems to implicitly mirror the "new code" format of understanding preceding advice giving. The PPG SOP characterizes this final phase as a space where residents are provided feedback on the process itself, so rather than coaching particular skills, the houseparent focuses on meta-communication. If the PPG generally and the problem solving phase in particular are the testing ground for the adolescents, then this summary is the reporting of the grades earned. The SOP suggests that individual houseparents should not let their summaries become overly predictable, critical, or directive, "…this is not a 'verbal spanking'" (p. 3). Instead the houseparent can take the opportunity to link together common themes from the group, encourage continued "processing" and point to next steps. Most often, the summary phase follows the general premise outlined here. The focus of the feedback is quite broad and moves between the group and the individual. In other instances, the summary can become more individualized, setting up a new challenge or test beyond the PPG group as an attempt to work on the transfer of skill from one context to the next.

The call for accountability is an undercurrent of the entire PPG process, from reporting "…since my last PPG, I've been working on…" to the houseparent's summary asking for continued efforts beyond the confines of the group. The question seems to be "What are you going to do about the problems at hand?" The question applies not only to this moment but also to the near and more distant future helping with the important aspect of generalizing the residents' adaptations. Although detailing the PPG process

cannot account for every aspect of the RTC program, it does provide a clear example of the RTC's incorporation of the PPC assumptions discussed earlier. Importantly, these assumptions, particularly the view of problems as opportunities for teaching and learning, are quite closely linked with the premise of an emotion coaching philosophy (Gottman et al., 1997).

The PPG stands as an exemplar of the implicit and engrained approach to "problems" taken by the RTC. While the RTC does not explicitly promote the usage of or train its staff in techniques for "Emotion Coaching," I argue that coaching is an implicit component of the RTC program. It should also be noted that RTC is deeply committed to including parents in the intervention process. Familial inclusion in the intervention includes the following: U.S. mail, weekly phone calls at designated times and for designated periods, on-campus visitation, off-campus visitation, leaves of absence from the facility/state, parent seminar weekends,[7] and family therapy sessions. According to the RTC Employee Handbook, family therapy sessions are typically conducted twice per month of the residents' enrollment (Balmer, 2005).

The goals of any given therapy session are linked with the needs of the resident and his or her family. However, the sessions often involve the discussion of issues raised or encountered during the adolescent's week at the facility. Raising these issues can provoke discussion of past events, patterns of behavior, or more productive methods of managing the issue in the future. These discussions are often emotional or emotion eliciting and provide an opportunity for both parents and adolescents to respond to one

[7] Parent Seminar weekends are opportunities for the parents of residents to come together at the RTC facility for large group interactions. The seminars dedicate time to trust building activities, group therapy, and individual family therapy in person (most "regular" family therapy sessions are conducted via teleconference).

another. Given the RTC's "problem solving" approach, these therapy sessions have provided a rich yet contained (readily accessible) scene for the observation of emotional interaction of parents and adolescents. The therapy sessions have also allowed access to the guidance of the therapist, in other words, the therapist's coaching of emotion coaching.

Adolescent Development

In the introduction to this document and throughout the review thus far, I have raised the point that adolescents have needs that are unique to their stage of life. The demands of adolescence place demands on familial interaction and, as discussed above, on methods of professional intervention. In what follows, I offer a review of adolescent specific-issues found in the developmental literature that helps to clarify the role of this investigation in addressing gaps in current conceptualizations of emotion communication among parents and struggling teens.

The review is organized by the common foci of psychological theories of adolescent development.[8] Broadly speaking, theorizing about adolescent development seems to coalesce around answering two important questions. First, is adolescence a distinct phase of human development? Second, is adolescence a characteristically turbulent and therefore an emotionally volatile phase of development (Miller, 1989)? Finally, I will discuss potential "outcomes" of adolescent development related to emotional competence. The review begins by addressing the issue of phase distinctiveness.

[8] Miller includes biological, psychoanalytic, social-cultural, and cognitive theories as broad categories of psychological theory pertaining to development.

One way to distinguish adolescence as a phase in overall human development is to characterize the phases that precede and follow it. Siegler (2000) for example, argues that learning is *the* task of childhood, and performing, is *the* task of adulthood. The literature consistently suggests that adolescence, on the other hand, is characterized by the intimately linked processes of identity exploration and individuation (i.e., the re-negotiation of individuality and connectedness between parents and their adolescent children) (Grotevant & Cooper, 1985; Lapsley, 1993; Miller, 1989; Vartanian, 2000). In fact, the process of individuation might be described as learning to perform competently as an adult. In this way, individuation paradoxically links adolescence to childhood, and adulthood and distinguishes this developmental phase from them.

Discussions of identity development and individuation are typically grounded in the work of Erikson (1968) and by extension Marcia (1966). For Erikson the salient issue of adolescence is the achievement of a coherent identity after having worked through a period of identity diffusion and crisis. Marcia's work establishes both conceptual and operational clarity regarding the transition between identity diffusion and identity achievement. The seminal work outlines something of a developmental sequence for adolescents that rests within the bounds of Erikson's polar alternatives of crisis and commitment. That is, Marcia outlines stages or statuses of identity achievement according to relative exploration of and commitment to a range of diverse ideological alternatives (e.g., occupational choice, religious beliefs, political affiliation).

Four statuses are identified (i.e., diffusion, foreclosure, moratorium, and achievement). Diffused identities remain uncommitted to a particular set of beliefs while individuals with a foreclosed status have committed to a set of beliefs, often influenced

by others including parents. Beliefs of foreclosed adolescents are often difficult to distinguish from those of their parents, according to Marcia. The moratorium status is the "crisis" period. Adolescents at this stage are actively engaged in the difficult task of negotiating between their own wishes and those of their parents. Although vague commitments begin to emerge during this status, the true mark of moratorium is the engaged consideration of alternative ideologies. Having experienced "crisis" (i.e., worked through alternatives), the adolescent may reach the identity achievement status. Here the adolescent is firmly committed to a particular set of beliefs that may or may not be in line with those of his/her parents.

Subsequent research has demonstrated that identity achievement is unlikely to occur before the age of 18 and that moratorium is most likely to occur during middle adolescent years (Coleman & Hendry, 1999). Despite these broad generalizations regarding the statuses outlined by Marcia, little evidence has been provided to allow for definitive conclusions about a particular developmental sequence *except* that moratorium (i.e., exploration) seems to be a prerequisite to identity achievement (Waterman, 1982).

Grotevant and Cooper (1985) set the stage for a more contemporary view of individuation focused on identity exploration and argue that the process is facilitated relationally. They describe what I would call a dialectical perspective on identity exploration. Their work points to the context of parent-adolescent interaction as more or less conducive to the renegotiation of the relationship. Here individuation is wrought out communicatively in the tensions between self-assertion (i.e., the expression of one's own point of view), separateness (i.e., the distinctiveness of self from others), mutuality (i.e., a sensitivity to others' points of view), and permeability (i.e., responsiveness to others'

points of view). Clearly, this perspective suggests, "…both individuality and connectedness (i.e.,, an individuated relationship) would be predicted as providing for its members the context for exploring and clarifying individual points of view" (Grotevant & Cooper, 1985, p. 416). In essence, the authors suggest that in managing the push and pull of these tensions, adolescents and parents are free to explore the (a)symmetry of their relationship, and the adolescent can begin to establish a coherent individuated identity. The importance of the relational context will be returned to below. For now I will discuss the related issue of egocentrism.

Adolescent Egocentrism and Cognitive Development

"Egocentrism is a Piagetian concept that refers to a lack of differentiation between some aspect of self and other" (Lapsley, 1993, p. 562). Elkind's work identifies two ideational patterns indicative of adolescent egocentrism. The first of these ideational patterns, imaginary audience (IA), is described as an issue of self-consciousness. Adolescents become increasingly capable of abstract thought (e.g., thinking about what others may be thinking). The tendency is to believe that others in the immediate vicinity are as concerned with the adolescent's thoughts and behaviors as he or she is (Elkind, 1967; Elkind & Bowen, 1979). Here "audience" implies that the adolescent perceives him or herself to be the object of attention and "imaginary" refers to the difference between perception and reality. Lapsley's (1993) review of egocentrism lists a number of "adolescent phenomena" attributed to (IA) including,

> …heightened adolescent self-consciousness, flamboyant behavior and faddish dress, great need for privacy and reluctance for self-disclosure, concern with shame, shyness, and embarrassment – all of which are

> reactions that reflect the feeling of constantly being evaluated, watched and judged by peers. (p. 563)

The conclusion drawn in the literature is that these ideations are false or faulty at best.

The second ideational pattern under the Elkind model is referred to as the personal fable (PF). The essence of PF is that the adolescent views the self as unique, omnipotent, and invulnerable. Vartanian (2000) calls this a problem of "overdifferentiation" (p. 642). Indeed, Elkind suggests that the adolescent fails to recognize the possibility for commonality of experience and/or emotion (e.g., no one understands me; no one feels like I do; those things don't happen to me). Adolescent risk behaviors are attributed to PF ideation. Again, Elkind's assumption is that PF is evidence of cognitive immaturity (i.e., having reached formal operational thought but not mastered it). While young adolescents have the ability to think abstractly, they have only a limited grasp. In the tradition of Piaget, Elkind (1967) argues that with experience (i.e., interaction with others) the adolescents encounter enough evidence to suggest it is necessary to reorganize their *faulty* thought structures.

A New Look at Egocentrism and Individuation

Researchers have noted problems with Elkind's original conceptualization of egocentrism. After reviewing the literature, Vartanian (2000) concludes that "[e]mpirical evidence supporting the theoretical link among imaginary audience and personal fable ideation and formal operational thinking has emerged only infrequently and has been tenuous at best" (p. 642). Others have questioned the logic of the theoretical argument (Lapsley & Murphy, 1985; Lapsley, 1993). Why would reaching the most advanced stage of cognitive development result in self/other differentiation errors? Should not the ability

to think abstractly eliminate the very issue it is said to have created? And, if the argument is that these thinking errors are attenuated only by continued cognitive development how can formal operations stand as the *final* stage of development?

The "new look" explanation has been to deemphasize cognitive development and shift to a focus on the concurrent developmental process of individuation. Under this theoretical umbrella, IA and PF are recast as normative coping mechanisms as opposed to normative thinking errors (Lapsley, 1993). Lapsley writes that IA and PF are "… "illusions" that allow the adolescent (and postadolescent) to cope with the process of self-delineation and individuation and are, thus, positive features of the adolescent experience" (p. 567).

In sum, the "new look" at egocentrism claims that adolescents are not simply confounded by their newly acquired ability to think abstractly (i.e., differentiate self/other). Rather, they are attempting to cope with the normative dilemmas of renegotiating the emotional and structural changes inherent in the individuation and identity exploration processes. As Grotevant and Cooper (1985) have suggested, the process of identity exploration is not a unilateral separation from parents. The process involves the goals of both individuality and connectedness. Lapsley's conception of IA and PF within this process can be easily linked to each of these goals (Lapsley, Jackson, Rice, & Shadid, 1988). IA is considered the natural response to the need to retain interpersonal connection, even if imagined. And, as Vartanian suggests, "[e]mphasizing feelings of uniqueness, omnipotence, and invulnerability (i.e., engaging in personal fable ideation) helps the adolescent to conceive of the self individualistically…" (p. 647).

Revealing itself to be both an intra- and interpersonally salient issue for adolescents, individuation stands as a clear demarcation of the developmental phase. Individuation then seems to answer the first question posed in the introduction of this section (i.e., is adolescence a distinct phase of human development?). The second question (i.e., is adolescence a characteristically turbulent and, therefore, an emotionally volatile phase of development?) is not unrelated to the first. In fact, many popular and academic writings about adolescence make the claim that emotionality is *the* distinguishing characteristic of adolescence. I turn now to exploring the emotional lives of adolescents.

The Storm and Stress of Adolescent Development

Popular notions of adolescence assume that this developmental period is distinguished by emotional upheaval. These often taken-for-granted conceptualizations of adolescent life can be traced to the "storm and stress" theory advanced by Hall (1904). Hall suggested that adolescence is characterized by an increase in conflict with parents, a constant swing of emotional extremes and an increased tendency to engage in "risky" behavior (Arnett, 1999). Under this model, it is emotional volatility that sets adolescence apart as a distinct phase of human development. However, research into the daily experience of emotion (Larson, 1989; Larson & Lampman-Petraitis, 1989; Larson, Moneta, Richards & Wilson, 2002) and adolescents' reported symptoms of psychological stress (Siddique & D'Arcy, 1984) offers only tempered support for "storm and stress" as *the* distinguishing characteristic of adolescence.

In fact, Coleman and Hendry (1999) argue that the research literature consistently returns the same results:

> …while a minority of young people experience what might be called a stressful or turbulent adolescence, the majority adjust relatively well. Research demonstrates that the majority are not alienated from their families, do not have major psychiatric disorders, do not experience a total breakdown of communication with their parents, do not go through serious identity crisis, and so on. (p. 209)

An examination of United States Census Data in conjunction with reports from the Substance Abuse and Mental Health Services Administration (SAMSHA) run by the United States Department of Health and Human Services seems to support Coleman and Hendry's assertion. The reports indicate that there were approximately 42 million adolescents (i.e., 10-19) in the United States in 2007.[9] In that same year 3.1 million adolescents between the ages of 13-17 participated in some form of mental health intervention. Importantly, and unfortunately, the SAMSHA report also indicated that even in cases where the participants recognized the need for help with chemical addiction and/or mental health services, the most commonly cited reason for not seeking that help was an inability to meet the financial costs.

Despite the apparent underestimation of the number of "struggling teens" in the U.S., the evidence clearly indicates that volatility, turbulence, and stress are relative terms in their actual manifestations. While there are indications of an increase in conflict with parents (Laursen, Coy & Collins, 1998), an increased capacity for mood disruptions (Larson & Richards, 1994), and increased rates of participation in risky behavior (Arnett, 1992) during adolescence, the majority of American families do not find themselves in

[9] The US Census Bureau estimates for 2007 indicate that "adolescents" between the age of 10-19 were projected to reach 41,820,035.

need of professional intervention as a result. Arnett's (1999) argument for a modified version of Hall's storm and stress thesis implies that,

> …storm and stress in adolescence is not something written indelibly into the human life course. On the contrary, there are cultural differences in storm and stress, and within cultures there are individual differences in the extent to which adolescents exhibit the different aspects of it. (p. 324)

The literature suggests that increased adolescent emotionality is skewed negatively (i.e., feelings of loneliness, solitude, and depression increase until late adolescence) (Larson, 1991). Contributing factors to the increase in reports of negative emotion have been identified as the number of negative life events adolescents become exposed to (Larson et al., 2002), the adolescent's ability to think abstractly about interpersonal relationships (Hauser & Safyer, 1994; Riley, Adams & Nielsen, 1984) and emotional transmission between parents and their adolescent children (Larson & Richards, 1994).

In related investigations, Silk, Steinberg, and Morris (2003) have provided evidence that indicates that deficiencies in emotion regulatory tactics (i.e., denial, rumination and/or impulsivity) are linked to increased symptoms of depression and anti-social behavior. What seems critical then is not whether adolescence is an emotional phase of development, but rather, how adolescents express, cope with, and regulate their emotional experiences. Thus with the modification of the storm and stress thesis, the question becomes "How do adolescents learn to regulate emotions competently?" To begin to answer that question I will outline a broad trajectory of developing emotional skills from childhood to adolescence.

Developmental Trajectory in Relation to Emotional Competence

As will be described below in more detail, Saarni's (1999) conception of emotional competence is heavily influenced by social constructionist perspective which focuses attention on the interactive nature of emotion expression and regulation according to the demands of the context. For Saarni, emotional competence is reflected in an individual's ability to recognize emotional experience in the self and/or another and to develop both effective and appropriate responses that aid in the negotiation of particular interpersonal interactions dependent on contextual goals.

This conceptualization of competence is in line with Siegler's (2000) ideas on learning for children. For Siegler, a focus on learning means attending to the ability of children to adjust to the demands of a situation, the processes that lead to "discoveries" of new strategies or approaches to problems, and how these discoveries are generalized once they emerge. Not only is emotional competence evidenced in interaction, it is derived from interaction with others and with the world. "Proto-manifestations" of emotion skills are evident in early childhood and are continually cultivated or inhibited in interaction with primary caregivers (mothers are the most often studied caregivers) (Saarni, 2000).

This perspective assumes that emotions, both positive and negative, are manageable and not separate from the ability to reason (Fonagy, Gergely, Jurist & Target, 2002). Indeed, here emotions are intimately linked with one's ability to understand his/her interaction with the world around him or her. As Planalp (1999) suggests, the function of emotion in everyday conversation is to tell us what matters to ourselves and to others. Emotions can indicate what is important for children and adolescents to learn. In this way, emotional experience, expression, and regulation allow an individual to

develop a sense of self in relation to others. As such, I argue that emotionality should be considered an important component in the process of individuation for adolescents.

From Childhood to Adolescence

A developmental trajectory that falls in line with this conception of emotional competence would account for the "proto-manifestations" of skills within the first 2 years of life. These manifestations, according to Saarni (2000), are reflected in social referencing behavior: the recognition and adaptation of responses to emotion in the child's immediate environment. Fivush, Reese and Haden (2006) describe the tendency of caregivers (mothers) to continually increase the cognitive demand on their children during reminiscing sessions. With a mother's perception that the cognitive ability of her child has increased, she will ask for more elaboration from the child during reminiscing/ storytelling and provide more elaboration herself during recall sessions. Fivush et al. (2006) have been able to show that prosocial outcomes are related to the elaboration styles of mothers. Later research, described below, includes emotion regulation capabilities among those prosocial outcomes. For now it is important to note the importance of these recall sessions in the ongoing cognitive development of children and adolescents.

Habermas and Bluck (2000) suggest that at the onset of adolescence, individuals experience normative contextual pulls to begin to provide coherent autobiographical accounts (i.e., identity exploratory issues). In addition, the authors argue that the research suggests that around the time of late childhood and early adolescence (i.e., ages 9-11), individuals have attained the cognitive abilities necessary for providing coherent stories

(e.g., temporal, biographical, causal, and thematic cognitive abilities similar to Piaget's formal operational thinking). Given the findings regarding the progression of elaborative parenting (Fivush et al., 2006), it be might inferred that the ability to produce coherent autobiographical accounts is nurtured by the elaboration styles of primary caregivers (often mothers). Further evidence of the influence of parents in the broad processes of socialization is provided by Arnold, Pratt, Hicks and Fiese's (2004) book chapter which describes the adoption of parental "voice" in children's autobiographical stories. The adaptation of a parent's voice (or not) in familial storytelling offers some insight into the extent of adolescent identity exploration and individuation.

Work by Thorne, McLean and Lawrence (2004) suggests that the inclusion of parental voice during autobiographical storytelling may take the form of simple lessons ("don't do that again") or the form of self –reflective insights ("I learned that I am self-reliant"). Thorne et al. suggest that insightful stories often stem from the recollection of tension- filled events. Pasupathi (2003) also points to the sharing of stories as a process related to one's ability to regulate emotions where the goals of the teller (i.e., to regulate emotion or not) are met with a receptive and agreeable audience, particularly for males. Consider, for example, the emotional component and prevalence of reminiscing during the family therapy sessions to be studied in this investigation. The recall of difficult or disturbing situations can provide moments for adolescents, therapists, and parents to (re)consider their actions and prepare for similar future situations. In combination, these articles suggest that emotion-eliciting stories (e.g.,, tension-filled) allow for moments of emotion regulation and, in turn, provide a context for continued socialization (i.e.,, learning) of emotion regulation (Thorne et al., 2004). McLean, Pasupathi, and Pals

(2007) suggest that the reasoning and self-reflection involved in constructing autobiographical accounts, whether they are shared with others or not, force the individual to integrate sometimes disparate experiences, which in turn provide the basis for some semblance of a continuous self-concept.

With regard to the development of emotional competence, Saarni (2000) cites the work of Gottman, Katz, and Hooven (1996; 1997) as important additional evidence in support of the social context (particularly the family) as a critical component in the developmental trajectory. As will be discussed in greater detail below, this work refers more directly to the discussion of emotion or meta-emotion than that of some of the narrative researchers discussed above. For Gottman and colleagues (1997), the topic of discussion itself is emotion, whereas for some of the narrative research reviewed, emotion and emotion regulation are attached to the discussion of recalled life events (McClean et al., 2007; Pasupathi, 2003; Thorne et al. 2004).

The "Telos" of Adolescent Development

Marcia (1966) suggests that identity achievement is the ultimate goal of adolescent development. The literature seems to suggest that well adapted, well developed and/or competent adolescents have integrated with peer/friend groups, have achieved academically, and have reached certain ideological commitments whether in line with those of their parents or not. It is also equally true that along the way to these "outcomes" well-adapted adolescents (seeking individuation) engage in behaviors that may be described as risky or reckless (Arnett, 1992; Jessor, 1992). These behaviors are normative and even necessary pieces of the individuation process. One hallmark then of a

"developed" adolescent, is the ability to see oneself in relation to but separate from others, particularly one's parents.

Closer examination of the developmental literature, however, paints a more complex picture. Indeed, it seems more likely that identity and individuation are relative and moving targets deeply rooted in the context of familial interaction (Grotevant & Cooper, 1985). Lerner's (1982) description of the lifespan or contextual approach (i.e., a continual process of adaptation and integration of lived experience) helps to clarify this point. Lerner describes a goodness-of-fit model of adolescent development where the adolescent simultaneously changes and is changed by his/her environment and interaction partners. Broadly speaking, the model suggests that an important outcome of development is the nurtured ability to recognize opportunity for self-efficacy as it presents itself in particular situations. Lerner writes,

> …a life-span developmental perspective emphasizes process and, as a consequence, a key concern in the application of the goodness of fit notion is the identification of the antecedent changes that resulted in a particular fit at a specific time and, in turn, specification of the consequences of this fit for later development. (pp. 361-362)

It seems then that the ability to think abstractly about self in relation to other and to negotiate the tensions of self, relationship and environment are important outcomes in and of themselves. The *telos* of adolescent development is, in a sense, the ability to adapt according to the social and emotional demands of the situation.

I suggested earlier in this review that adolescence might be aptly characterized as a period of learning to perform competently as an adult. This investigation considers emotional competence to be among the most important skill sets continually refined during the adolescent stage of development. Despite characterizations of competence as a

life-long and contextually bound phenomenon, much of the research dedicated to the investigation of emotional competence focuses on young children and preadolescents (Saarni, 1999). However, as suggested above, emotional expression and emotion regulation in particular are critically important to navigating the relative storm and stress of adolescence (Silk, Steinberg, & Morris, 2003). In the words of Saarni, emotional competence includes "… the emotion related capacities and abilities an individual needs to deal with the changing environment such that he or she emerges as more differentiated, better adapted, effective, and confident" (p. 4).

In sum, the reviewed literature and Saarni's writings suggest that a clear link exists between "mature" emotional competence and the quality of an individual's engagement with others in the socialization processes continued from childhood into adolescence. The most obvious overlap between these readings and the focus of this investigation is the explicit attention paid to communicative (social constructionist) aspects of emotional competence development. The articles stress the importance of bi-directional influence (e.g., parent to child, child to parent), and in turn this investigation seeks to navigate the shifting symmetry between parents and individuat(ing) adolescents (Grotevant & Cooper, 1985; Vartanian, 2000). In addition, the reviewed literature helps to clarify the processes involved in establishing a consistent yet flexible sense of self (Lerner, 1982). The research seems to reinforce the idea that development is an ongoing event and that deficits or incompetencies (e.g., of emotion regulation) might be mitigated over time (important given the population of interest). Finally, the literature suggests that the exploration and development of an individuated identity is an emotional journey

calling for a particular set of skills which one can employ to varying contexts. I turn now to outlining those skills in detail.

Emotion Regulation Theory (ERT)

All of the literature reviewed above leads to the conclusion that the quality and character of parents' interaction with their children has a significant impact on identity exploration, individuation, and the socialization of emotional competence. Work done by Gottman and colleagues (1996) provides some insight into the patterns of parent-child interaction relevant to this investigation. Broadly speaking, their work suggests that parents' general philosophies of emotion mediate their socialization of (in)competent emotion regulation skills in their children. Given the importance of emotion regulation to the daily lives of adolescents (Silk et al., 2003) and Saarni's conception of the ongoing development of emotional skills, (e.g., regulation), this study explores the quality of parent-adolescent interaction involving emotion.

This final section of the literature review clarifies ERT as the guiding framework for this investigation. The work of Gottman et al. (1997) provides clear distinctions between particular parenting styles or strategies (e.g., supportive, scaffolding, and derogation), their cognitive origins (i.e., meta-emotion philosophies), and their associated outcomes (i.e., emotional competence, academic achievement, physical/psychological well being, peer integration, familial functioning). In the following sections, each of these components is addressed in more detail.

Meta-Emotion

Meta-emotion philosophies encompass both cognitions and emotions/feelings about emotions (Gottman, Katz & Hooven, 1997). Gottman et al. (1997) suggest that parenting, as a locus of study, has been investigated with regard to: "(a) the predominant parental affects toward the child, and (b) predominant parental discipline techniques" (p. 12). The authors go on to say: "What we think is missing is how the parent feels about and relates to specific emotional displays by the child, and how this might relate to the parent's feelings about his or her own emotions" (p. 13).

To that end, Gottman et al. (1997) conducted Meta-Emotion Interviews questioning parents about their experiences of sadness and anger, their philosophies regarding emotional expression/suppression, and their feelings, attitudes, and responses to their children's anger and sadness. The interview transcripts were analyzed (coded) along three dimensions. First, the researchers were interested in *awareness of one's own emotion.* Evidence of this "awareness" was manifest in the participants' ability to talk about and differentiate between types and intensities of their own experienced emotions. Second, the researchers were interested in the participants' ability to demonstrate *awareness of their child's emotion*. This type of "awareness" was evidenced in the participants' talk about recognizing the cause of a particular emotion, distinguishing one emotion from another, and demonstrating an interest in the child's emotion. Finally, the researchers assessed *coaching the child's emotion*. Evidence of coaching involved talk about helping the child recognize and label emotions, demonstrating respect for the child's experience, intervention, and education (note the similarities to Saarni and Ginott). The analyzed transcripts provided evidence for two broad categories of parenting

strategies (i.e., coaching and dismissing) stemming from the parents' meta-emotional philosophies/structures. This study looks at these philosophies more broadly.

Emotion Coaching

Coaching parents can, generally speaking, accept, tolerate, and even share the emotions of their children. These parents recognize emotional experiences as opportunities for both connection and self-assertion. Empathy, according to Gottman (1997), is the foundation of emotion coaching. "When we seek to understand our children's experience, they feel supported. They know we're on their side" (p. 75). Recall Ginott's (1965) new code of communication: "…that statements of understanding *precede* statements of advice or instruction" (p. 21). Gottman suggests that empathy breeds empathy. That is, parents or caretakers who use empathy when communicating with their children foster the development of empathy in their children. Furthermore, Gottman suggests that coaching empathy enhances children's emotional competence (i.e., their ability to "read" and "react" to emotional interactions). While acceptance of emotion is an important component of the coaching style, teaching is the most important distinguishing characteristic of the styles. The meta-emotion interview data revealed that some parents allow for the expression of emotion but then offer no guidance to their children. *Laissez-faire* parents assume that emotions are natural but passing states, to be left alone. The passive acceptance of emotion provides the child with no clear guidelines for future behavior. Emotion coaching parents are actively engaged and provide clear boundaries and expectations for their children's emotional behavior.

As discussed in the introduction of this document, Gottman outlines five coaching behaviors: (a) being aware of the child's emotions, (b) recognizing the emotion as an opportunity for intimacy and teaching, (c) listening empathetically and validating the child's feelings, (d) helping the child verbally label emotions, and (e) setting limits while helping the child problem solve. Again, I ask the reader to recall Saarni's basic skills of emotional competence: an awareness of one's own emotional state, an ability to discern others' emotional states, the ability to use the vocabulary of emotion, and the capacity to be empathetic and sympathetic. Moreover, consider these basic skills in relation to the issues of self-assertion and connectedness during adolescent identity exploration (Grotevant & Cooper, 1985). Accepting the child/adolescent's emotional experiences as real and important events offers him/her the most basic form of recognition – love (Honneth, 1995).

Emotion Dismissing

Gottman et al. (1997) broadly define a second parenting strategy as dismissing. A focused review indicates, however, that this style is comprised of both dismissing and disapproval behaviors. The dismissing or disapproving parents are, in contrast to the coach, uncomfortable with their child's anger or sadness. Dismissing parents attempt to distance themselves from their children's experience rather than recognizing the opportunity for intimacy, empathy, or coaching. Disapproving parents are critical of their children and attempt to control or limit the expression of emotion. In addition, the disapproving parent is likely to point out what is wrong with experiencing and/or expressing sadness or anger instead of addressing the emotion itself. Gottman (1997)

acknowledges that the enactment of these styles (i.e., coaching and dismissing) can and often does overlap; however, one style will typically outweigh the other.

The dismissing parenting style (broadly defined) recalls what Honneth (1995) describes as disrespect in two very apparent ways. First, the child (adolescent) is not allowed to experience emotion or is denigrated for doing so. Second, he or she is denied the "right" to express him or herself or is often punished for doing so. In these types of environments the adolescent is not recognized as an entity capable of understanding much less negotiating emotional situations. Again, as noted in the introduction, the dismissing parenting style undermines the development of a positive relation-to-self (i.e., self-confidence, self-respect, and self-esteem) and, ultimately, the development of social, moral, or emotional competence.

The parenting styles outlined above return the focus of this essay to the communicative practices that constitute familial patterns of conflict, negotiation, adaptation, and change. I offer here a few examples of coaching and dismissing metaphors uncovered by Gottman and his colleagues. Coaching parents with regard to sadness: *"I think sadness can be good and even productive"* and *"Sadness tells you to slow down."* Coaching parents with regard to anger: *"Anger gives me energy and drive,"* and *Getting angry can be a relief, like a storm that finally happens"* (p. 82). Compare these examples with the disapproval of dismissing parents: *"When people get angry they are just relieving themselves on others;" "they explode;" "they're out of control."* With regard to sadness: *"they are hopeless"* and *"defeated."*

MEPs in the Family Crucible

Armed with these meta-emotional philosophies, parents (and children) enter the "interpersonal crucible" and attempt to renegotiate the (a)symmetry of their relationships. With that in mind, reconsider the socialization environments where children's emotions are met with dismissive messages such as *"A child's anger deserves a time out"* or *"I get annoyed when my child acts sad"* (Gottman et al., 1997 p.83). Reconsider the constitutive power and importance of communicative practices in the development and facilitation of emotional competence. And finally, reconsider the increasingly influential role of adolescents in conversation with their parents. This study's communicative focus moves beyond the philosophies of parents and their children to a look at the actual constitutive behaviors, their Meta-Emotion Behaviors (MEB).

To date, researchers interested in MEP have almost exclusively looked at the parents of children under the age of 11 (Gottman, Katz & Hooven, 1997). Although recently some attention has been paid to adolescents (Katz & Hunter, 2007; Yap, Allen, Leve, & Katz, 2008), virtually no research exists that breaks the mold of top down (i.e., parent to child) transmission of MEP. These traditional models ignore the contextually contingent and ongoing nature of the emotion socialization process (Lewis, 1997; Saarni, 1999). In fact, I would argue that one important way adolescents begin to explore their independence is by laying claim to their own emotions and by rendering opinions about their relational others' emotions. In turn, the adolescent can play an increasingly influential role in their family's emotion socialization process.[10]

[10] This is not to say that a child, as opposed to an adolescent, has no relational impact. Rather I am suggesting that for the adolescent independence and self-assertion are more salient issues.

It is certainly not new to suggest that the parent-adolescent relationship is filled with tensions surrounding the (re)negotiation of autonomy and connection. Indeed these tensions are often taken as natural and necessary. While most families are able to emerge from these interactions relatively unscathed and stable, others are forced to turn to therapeutic interventions for any chance at a positive relational outcome. Despite the importance and prevalence of the process of familial (re)negotiations it remains relatively difficult to find research that delves into its interactive and emotional dimensions.

Research Questions and Rationale

This investigation advanced exploratory questions about families who turn to adolescent residential treatment centers (RTC's) for help. Specifically, I asked if differences, as evidenced in communicative behavior, can be detected in the enactment of meta-emotion philosophy (MEP) (Gottman, Katz & Hooven, 1997) across programmatic phases of RTC intervention. If so, what is the nature of these emotional exchanges? Despite explicit reference to and the implicit importance of communicative behavior, communication scholars have been slow to engage these lines of research traditionally dominated by social and/or developmental psychologists. This study picks up where their work has left off. In what follows, I outline calls for work in the ERT literature and advance formal research questions aimed at answering those calls.

Foundational Questions

In their original explication of ERT, Gottman et al. (1996) call for work that (a) is naturalistic, (b) tests for stability of MEP over time, (c) incorporates emotions beyond fear, anger, and sadness, and (d) measures the MEP of children. Unfortunately in more

than a decade, very little progress has been made on this research agenda. Work that is done on meta-emotion remains locked into laboratory settings where parents and their children are asked to engage in artificial tasks. Although Gottman et al. (1996) suggested looking into shame and guilt, no published work addresses specific emotions other than fear, anger, and sadness. Only recently has any published work attempted to address positively valenced emotions (Yap et al., 2008), and this work remains at the generalized, "positive" level. Tests of stability are virtually nonexistent save for test/ retest reliability scores on a scale reported by Hakim-Larson, Parker, Lee, Goodwin, and Voelker (2006). No longitudinal or cross-section studies have been published. And, although Yap et al. (2008) report on the importance of adolescent temperament and the likelihood of parents implementing coaching behaviors, no study considers the child/adolescent's meta-emotion philosophy.

I proposed the following foundational research questions to begin to address each of these calls:

> RQ 1: In what ways do the Gottman (1997) conceptualizations of MEPs converge with the naturally occurring talk (MEBs) during family therapy sessions?
>
> RQ 2: What is the profile of adolescent, parent, and therapist MEB across stages of therapeutic intervention for struggling teens?
>
> RQ 3: What emotions are salient during family therapy sessions across stages of therapeutic intervention for struggling teens?

These questions foreground the role of the child/adolescent, move away from a traditional focus on young children and their mothers, and explore the range of emotions expressed in actual interaction. In addition, these questions begin to address Eisenberg's (1996) separation of philosophy and behavior critique of ERT. As Eisenberg argued, the

theory is relatively unclear about the distinction between philosophy and behavior. I turn now to questions regarding the stages of intervention.

Questions of Difference Across Stages

The cross-section of participants in this investigation allows for an indirect assessment of stability and change with regard to MEB across the stages of intervention. Research questions 4, 5, and 6, could be considered a subsidiaries of research questions 2 and 3, respectively.

> RQ: 4 Are there differences in mothers, fathers, residents, or therapists MEBs within or between the stages of intervention?
>
> RQ: 5 Do the emotions expressed during therapy sessions differ across the stages of intervention?

Evidence reported by Yap et al. (2008) suggests that mothers' communicative behaviors, related to MEP, varied with adolescent temperaments. The evidence lends credence to the idea that MEB might vary depending on the source and/or target of the behavior. Research questions 6 and 6a address that issue.

> RQ: 6 Do MEBs differ depending on the source or target of any emotion?
>
> RQ: 6a Do MEBs differ depending on the emotion expressed by the source?

The final two research questions are specific to the RTC and provide important descriptive and exploratory information.

> RQ: 7 Do therapeutic tasks discussed during therapy sessions differ in frequency across the stages of intervention?
>
> RQ: 8 Is there any association between therapeutic task and emotions expressed in emotion episodes drawn from the therapy sessions?

Together these research questions provide inroads to the research agenda set forth by Gottman and colleagues (1997) more than a decade ago. The pursuit of these questions not only addresses gaps in the literature but also expands the boundaries of ERT. I turn now to a discussion of the methodological design and procedures.

CHAPTER III

METHODOLOGY AND METHOD

Strauss and Corbin (1998) describe the difference between methodology and method as a matter of (meta)theoretical commitment versus the practice of collecting and analyzing data. This investigation nests or embeds quantitative data (i.e., frequency data) within a largely qualitative study guided by the principles of a grounded theoretical approach (Strauss & Corbin, 1997). The complementary data help to answer distinct but related research questions regarding the discussion of and response to emotions during family therapy sessions conducted at a residential treatment center (RTC). In this chapter I outline the (meta)theoretical lenses through which I have conducted this exploratory research and provide a description of the steps taken to collect and analyze the data used to derive the inferences made in subsequent chapters. The underlying assumptions and analytic procedures described here carry with them a set of criteria for evaluation and ethical conduct. I will discuss these issues as well.

Metatheoretical Commitments

For me, *truth* lies somewhere in between the divergent poles of ontology. If a distinction can be made between *reality* and objective reality, then the door remains open to a pragmatic approach for the study of communication phenomena: an approach to the study of communication that is responsive, methodologically speaking, to the kinds of

questions being asked. I subscribe to the interpretivist idea that reality or meaningfulness is socially constructed between and among interactants (Cheney, 2000). I would however, also argue that social constructions can become reified (taken for granted) in patterned ways so that they become *a* reality if not an objective one. Patterns of communication, therefore, make shared understanding to some degree predictable and are both manifestations of and guidelines for the social construction of meaning.

I turn now to a discussion of my epistemological and axiological beliefs. I call on Anderson's (1996) discussion of objectivity, subjectivity, and idiosyncrasy for support in the following arguments. Anderson suggests subjectivity is not the appropriate polar opposite of objectivity. Rather idiosyncrasy offers a truer contradiction. It is idiosyncrasy that horrifies the objectivist. Idiosyncrasy occurs when a researcher allows his or her own biases to influence the interpretation of *text* in an undisciplined manner. Subjectivity on the other hand, as Anderson posits, "…occurs when the text is the subject of interpretation and brought into meaningfulness through a particular interpretive method…" (p. 23).

While I admit the impossibility of complete objectivity, I also reject idiosyncrasy, and work from the subjectivist claim that "…any objective fact is produced through consensual achievement" (Anderson, 1996, p. 24). Broadly, I see the tasks of the researcher as both interpretation and explanation. Under this rubric, I am charged with examining the patterned processes of social construction and concurrently with offering meaningful and disciplined interpretations of localized texts.

Borrowing from an interpretivist point of view (Lindlof & Taylor, 2002), I have taken seriously the concept of *verstehen*. That is, this process of inquiry has been an

attempt to understand, based on participants' situated communicative behavior, how emotions are discussed and responded to during family therapy sessions. I have attempted to uphold an ethic of analytic realism wherein the value and validity of the work is grounded in "…the social worlds of phenomena studied" (Altheide & Johnson, 1998, p. 292).

This commitment to lived experience responds and attends to the practices of relationship as they occur *in situ*. As such, I undertook this project accepting that interaction does not occur outside of cultural context, that research is an undertaking that implicates the researcher as well as the researched, and that "…inquiry is the professional practice of the social creation of reality" (Anderson, 1992, p. 355). Consequently, and in line with Altheide and Johnson's (1998) conception of analytic realism, I have viewed my task in reporting on this investigation as re-presenting my interpretation of the interactive processes enacted by the participants. To do so responsibly, it was important to think and write reflexively about my role as a researcher and member of the RTC community.

Participant – as – Observer

When compared with the classic typologies of fieldwork roles based on degree of participation, as outlined by Gold (1958), my work probably most closely resembles that of a Participant-as-Observer. My employment since October of 2005 as a Milieu Manager at the RTC granted me a uniquely engaged position with the therapists and adolescent residents, and to some degree, with their parents. My dual role as an employee and researcher was not hidden, but neither was it "advertised" until and unless the

therapist, resident and/or parent was invited to participate in the investigation. The resident's familiarity with my role as student and part time/full time staff helped to facilitate a relatively easy transition between these positions. In fact, in some cases my requests for "permission" to observe seemed to be out of place. I attribute this experience to the "taken for grantedness" of the activity (observation) given my role as "staff" as opposed to "student/researcher" in this setting.

I engaged in activities with my participants as I would normally, and I tried to limit discussion of the project, including answering resident and staff questions, until periods of down time so that participating residents would be less conspicuous. I did not want residents who were included in the study to feel either threatened or privileged; at the same time, I did not want residents who were excluded to feel unwanted or alienated. Although each "team" and the attendant staff became aware of my research objectives soon after my initial interactions with potential participants, there were very few inquiries and/or references to the project in a given day. I attribute this to my already intermittent interaction with each team, their more immediate and pressing therapeutic concerns, and the strategic ambiguity with which I framed the research process as a "project on emotional communication patterns in RTC's ." Ultimately the data collection process was a dialogic interplay between my uniquely emic and etic positions; positions which Eastland (1993) might suggest grounded, enabled, and informed my analyses.

While my employment granted and required action as a complete participant in the daily lives of therapists and residents, it did not automatically grant, nor was it necessarily typical to participate in the scenes (i.e., family therapy sessions) that were under direct observation. As such, I approached each transcribed therapy session as a

distanced but informed observer. Perhaps more accurately than by participation, my role can be defined functionally. Anderson (1987) outlined strategies for understanding member activities, including using past experience or present involvement to reflexively analyze participant behavior. In this case, my knowledge of and experience with the participants themselves provided a sounding board for the iterative and grounded comparisons conducted throughout the analytic process. As a check on the influence of my experiences, I recorded my personal responses to the participants' behaviors in memo form, noting reactions such as skepticism and/or surprise.

As an additional check, I engaged in document analysis. I viewed my observation of the recorded interactions as a "return to the field" wherein I have been deeply immersed and, therefore, potentially blind to taken-for-granted practices and norms. In some sense, I was already "native" (Pacanowsky & O'Donnell-Trujillo, 1983). To combat these potential limitations, that is, to make the familiar strange, I returned to the RTC Employee Handbook (Balmer, 2005) with a sense of naiveté to examine the facility's standard operating procedures and rationales. Deep reading and reflective notes provided a liminal, as described by Eastland (1993), space wherein I could stand as both participant in the (re)production and variation of the organization's stated ideals and observer attending to the relationships that exist within the RTC culture. As a result of those deep readings, I was able to select and make informed decisions about which portions of the therapy sessions to attend to more carefully as an observer. In this sense, these methods of engaging the field and gathering data (i.e., document analysis and observation) were mutually influential and beneficial.

Site Description

Participants in this investigation were drawn in a purposive and stratified fashion from the population of adolescents enrolled at an RTC located in the intermountain west. More specifically, resident families were recruited from each of the RTC's final four programmatic phases. Table 2 describes the RTC phases.

As discussed in the review of literature, the organization embraces the principles of positive peer milieu therapy (Vorath & Brendtro, 1985) and facilitates the engagement of parents with their adolescent children during the intervention via family therapy sessions. The RTC provides a uniquely rich environment for the observation of emotion communication among parents and adolescents. The facility houses five "teams" (three male only and two female only) of "struggling" adolescents. The campus includes the grounds, two residence halls, and the administrative/school building that occupies several acres in a relatively rural but increasingly urban residential area.

The RTC has the capacity to house approximately 115 residents throughout the year, and each team typically includes 18-21 individuals at any given time. The RTC census typically hovers around 80-85 residents. In the last 12 months the RTC population has reached a low of 46 and a high of 112 residents. At the time of this writing, the census stands at 77 total residents. In the original proposal for this investigation, I outlined plans to include female residents, but the recruitment of participants only produced one willing female resident family. As a result, these analyses did not include any female resident families. Although it is difficult to provide conclusive reasons for the limited response from the female resident population, I consider the following as

Table 2 *RTC Phase Descriptions*

	Characteristics	Transition Requirements
Orientation	Initial assessment period. Adolescent and Staff orienting to one another.	2 Weeks - Automatic
Explore	Adolescent is "going through the motions." Little or no commitment to therapeutic process or betterment of self. Responsibilities/privileges are limited.	Minimum 2 weeks on phase Active engagement in school, recreation therapy, and CD if applicable Presentation of "Autobiography" to peers
Apply	Resident begins to "buy in" to the therapeutic community Adolescent continues to have difficulty with negative influences/behavior Increased privileges: off campus acticities, increased phone time, off campus visitation. Increased responsibilities: community roles/jobs available	Minimum 2 weeks on phase Continued academic and Recreation Therapy improvement Letters of reconciliation Letter of intent – commitment to pro social lifestyle. CD –if applicable, AA Step 1 completed
Impact	Described as doing "…driven by internal value systems not external pressure." Far less susceptible to negative influences Increased privileges: off campus breakfast, late sleep, cross-team interaction. Increased responsibility: community leadership roles available	Minimum of 2 weeks on phase Continued academic progress Continued recreation therapy progress CD-if applicable, AA step 2 &3 completed
Test	Phase designed to see "…if the resident can 'walk the talk' with the training wheels off" Programmatic supports are slowly removed Pro social adaptations are internalized Increased privileges increased phone time, unrestricted campus travel, television, individualized outings Increased responsibility: Complete "team service project" – plan, implement, lead team community service project.	NA

Adapted from Balmer, (2005)

potential explanations for the differing response: a) more limited interaction between the therapists assigned to the female residents and me during the course of my employment, b) more limited interaction between the female residents and me during the course of my employment, and c) potential cultural mores (e.g., a "boys will be boys" attitude as opposed to a reluctance to disclose information concerning a daughter's indiscretions).

The current population of male adolescents stands at 43 residents. Male residents are distributed across the programmatic phases of intervention as follows, 2 (5%) of the 43 males are currently at the orientation phase, 20 (47%) are at the explore phase, 10 (23%) are at the apply phase, 7 (16%) are at the impact phase, and 3 (7%) are at the test phase.

On average, residents spend 6-9 months in the RTC before graduating, transferring, or terminating their enrollment. Given that this RTC is a "lockdown" facility, most residents do not come of free will. Although most residents are escorted by their parents to the facility, some require professional escort services both to physically remove the adolescents from their homes and to transfer them into the custody of the RTC staff. A large portion of the population report either chemical abuse or addiction and so participate in rehabilitative groups (i.e., Alcoholics Anonymous, Rational Recovery) on and off campus. Residents or their parents also report (often overlapping instances of) family conflict, poor peer relationships, poor school performance, and/or problematic self-image issues as antecedent conditions leading to enrollment at the RTC.

The RTC employs approximately 50-55 direct care staff including: 10 primary therapists, who council the residents in individual, peer group, and family therapy sessions; 7 recreation therapists, who engage the residents in a wide variety of physical

activities that encourage both individual growth and a sense of teamwork and/or group membership; 4 to 5 milieu managers for each of the 5 teams, who supervise and interact with the residents continuously throughout the day; and 2 team directors who supervise and train the milieu managers with regard to facilitating particular therapeutic groups for the residents.

Access to the Site

As an employee of this facility and as a researcher with a strong desire to work responsibly, I recognized the paramount importance of remaining sensitive to the participating families' needs and concerns. In October, 2009, I met with the RTC Executive Director and with the Director of Clinical and Milieu Services to negotiate entry to this site and to gain access to this population. Our discussion outlined the parameters of resident/staff confidentiality, length and nature of my observations, and informed consent (including self-disclosure regarding my role and research interests). To protect the identity/confidentiality of the research participants, I agreed to alter their names and any identifying information, and to obscure the name and location of the RTC. Following University of Utah Institutional Review Board policy, I agreed to avoid or discontinue documentation of any interaction at any point in the process if participants indicated that they did not or no longer wished to participate in the study.

We agreed that direct, study–related contact with participants (i.e., requests for participation, the audio recording of one family therapy session per participating family group, and the distribution of a questionnaire) would begin in November of 2009 starting with a meeting with all of the RTC therapists and concluding upon collection of the

audiotaped therapy sessions. One constraint I imposed upon myself with regard to participant recruitment was to disqualify those residents with whom I had direct supervisory contact.[11] It was my fervent desire to avoid, as much as reasonably possible, the abuse of my position within the organization as (in)direct pressure to participate in this investigation. In line with Taylor's (1991) description of "ethically" leaving the field, I hope to have left the participants "…no worse off for having let [me] study them" (p. 246). In so doing, I hope to have laid the groundwork for potential future research endeavors.

In an effort to ensure informed consent, I agreed to provide all willing and potential participants with both verbal and written descriptions of the investigative procedures using IRB-approved consent forms. Finally, I agreed to represent myself as a researcher/student/employee interested in "patterns of emotion communication." I chose to remain at this level of abstraction regarding my research purposes for two reasons. First, I interpret informed consent to include transparency about who is conducting the research and reassurances regarding safeguards against using my position to influence their experience or progress at the RTC.[12] I wished to offer the participants adequate information to freely accept or reject my presence. Second, I believe this level of abstraction allowed for reasonable transparency without influencing the behavior of the participants, with particular care not to elicit more socially desirable performances.

[11] I am referring here to monthly medical charting responsibilities. Each milieu staff is required to "chart" on an assigned set of residents regarding their progress toward specific behavioral goals outlined by the resident's primary therapist. I was assigned four male residents; I did not request participation from these residents or their families.

[12] As I did not have direct/supervisory contact with those residents who participated in this investigation, I also had very little influence on their progress at the RTC.

Participant Recruitment Procedure

Once I was granted access and received IRB approval, participant recruitment unfolded as follows. I requested time during a regularly scheduled clinical meeting with the RTC therapists. All but one of the participating therapists attended the meeting. I later requested and met with that therapist individually. During the meeting(s) I specified the purpose, procedures, voluntary, and confidential nature of the proposed project, and I addressed the anticipated risks/concerns indicated by the therapists (e.g., evaluation of the therapist, sharing of recordings with therapist supervisors, residents' diagnoses as uncontrolled variables). I stressed my desire to remain as unobtrusive to the therapeutic process as was reasonably possible, assured the therapists that I was not evaluating their technique nor providing an evaluation of their services to their supervisors, and reminded them that I was focused only on patterns in the discussion of emotion during their sessions. With the aid of the participating therapists, I was able to recruit the families of residents distributed across the final four programmatic phases. Upon the recommendation of participating primary therapists, letters of request for participation, containing the same information presented to the therapists, were sent to the parents of targeted residents.[13] Parents who were willing to participate (as indicated by returning a signed letter) were asked, in turn, to grant me permission to request participation from the residents themselves via IRB-approved letters of assent outlining the nature of their involvement. Ultimately, each potential participant (i.e., residents, parents, therapists)

[13] I assumed that risks and benefits were weighed on a case by case basis and therefore not all residents under the care of a given therapist were appropriate candidates for participation. I left this to the discretion of the therapists.

was given an opportunity to self-select in or out of the investigation without bearing on his or her status with the RTC.

Participant Description

This investigation included 15 of the 43 (35%) male RTC residents. The resident participants in this investigation are broken down across the phases of intervention as follows: 4 (27%) are at the explore phase, 5 (33%) are at the apply phase, 4 (27%) are at the impact phase, and 2 (13%) are at the test phase. The sample provides a reasonably representative cross-section of the total male population covering 20% of all male residents at the explore phase, 70% of all males at the apply phase, 57% of all males at the impact phase, and 67% of all male residents at the test phase. Residents in the orientation phase were excluded for two reasons. First, residents (typically) are automatically advanced to the explore phase after the first 2 weeks at the facility. Second, communication between the resident and his parents (typically) is severed during the orientation phase.

Residents

As indicated above, the sample included 15 male residents who ranged in age from 14-17 years (M = 16.33, SD = *1.03)*. Thirteen (87%) of the 15 residents reported their ethnicity as White, non-Hispanic; the remaining 2 (13%) residents reported their ethnicity as Black or African American, non-Hispanic. The residents reported having spent between 2 and 18 months enrolled at the RTC (M = 5.92, SD = 3.93). In instances where the RTC did not represent the residents' first form of therapeutic intervention (13

of the 15 cases), residents reported enrollment in "any therapeutic intervention" ranging from 2 to 48 additional months (*M* = 10.12, *SD* = 11.36).

Parents

Twenty-six parents of the residents participated in this investigation. These parents reported their age to range between 37 and 65 years (*M* = 49.20, *SD* = 7.66). Twenty-four (92%) of the participating parents reported their ethnicity as White, non-Hispanic. One parent (4%) indicated an ethnicity of Black or African American, non-Hispanic, and 1 parent (4%) indicated an ethnicity of American Indian or Alaska Native. Reports of marital status indicate that 21 (81%) of the parents are currently married. Two parents (8%) indicated that they were divorced. One parent (4%) reported being separated, and one (4%) indicated that she had been widowed. Frequency data indicate that 16 (62%) parents claimed to be the birth parent of their resident, 8 (31%) reported that they are an adoptive parent, and 2 (8%) indicated that they are the step-parent of their resident. Parents reported familial histories of therapeutic intervention ranging from 4 months to 10 years (*M* = 30.40, *SD* = 34.35).

Therapists

Five RTC therapists participated in the investigation. Each therapist was a White, non-Hispanic male ranging in age from 28 to 42 (*M* = 35.20, *SD* = 5.40). Therapists reported having worked in the field of social work between 3 and 19 years (*M* = 8.20, *SD* = 6.26), and tenures at the RTC ranged from 1 month to 6 years (*M* = 2.82, *SD* = 2.25).

Data Collection Procedures

Once I received therapist, parent, and resident consent/permission and assent forms, therapists were asked to designate the date and time of therapy sessions to be audiotaped. On the scheduled dates, I would provide the therapist with recording equipment including a voice-activated minicassette recorder, an omnidirectional microphone, one blank hour-long cassette labeled[14] and loaded into the recorder, and a box containing extra batteries for the recorder and microphone. Therapists and residents arrived at their regularly scheduled family therapy session following standard RTC/primary therapist practice, and the resident's parents were phoned and connected via conference call, per standard practice. On two occasions, the parents were physically present for the recording, having previously planned to come to the facility for visitation.

Therapists were instructed to remind members of the family group at the beginning of each session of the presence and use of an audio recording device for this family therapy session as well as the voluntary nature of their ongoing participation. In addition, the therapists were instructed to encourage the use of first names only to help protect confidentiality. The consent and instruction forms for the therapists indicated that their willingness to place the recording device in the 'on' position constituted their own consent to participate in the investigation. Therapists were also reminded before the sessions began and via the consent and instruction forms that for all members, participation was continually voluntary. The therapist therefore had the option to discontinue recording at any time, and he must discontinue recording if any member of

[14] Labels followed a simple format indicating Sex: M or F for male or female resident, Phase: E = explore, A = apply, I = impact, T = test, Family Group number: 1,2,3…
MA-1 indicates a male resident in the apply phase, family group 1.

the family group indicated they no longer wished to participate in the research project. No participant indicated before, during, or after recording that they no longer wished to participate.

Beyond an initial greeting and offering of instructions, I remained absent from the therapy sessions in an effort to allow the sessions to proceed naturally. At the conclusion of the scheduled therapy sessions, I returned to the therapist's office to collect and secure the recordings and to transfer the recordings to the transcriptionist's secure mailbox in the RTC mailroom. I received the transcriptions titled, with the labels indicated on the cassettes, via electronic mail and saved them on my password-protected computer at my home office. The original cassettes were returned in person from the transcriptionist. The data, in written and recorded form, remain in a locked file cabinet in my locked home office.

Questionnaires

Demographic questionnaires were mailed to the parents at the same time and in the same envelope containing IRB consent/permission forms. Instructions in a cover letter directed parents who chose to participate to return their consent/permission forms in one provided envelope and their questionnaire in a second. The dual envelopes helped to eliminate identification of the parent's questionnaires via their signatures or identification of their children. After permission forms were received from parents, cover letters, University of Utah IRB assent forms, questionnaires, and blank envelopes were distributed to the residents themselves.

In an effort to avoid issues of power, intimidation, and social desirability, an RTC liaison who was familiar to the residents, but not a direct supervisor, was asked to distribute the questionnaire packets and blank envelopes to the residents at the beginning of their weekly scheduled self-evaluation.[15] The questionnaires were distributed on days when I was not present. The RTC liaison was informed of data collection ethics and procedures and asked to verbally remind the residents that their participation was voluntary. Residents who participated were asked to place their completed questionnaires inside the blank envelope provided and return it to the RTC liaison. I retrieved the questionnaires in person from the liaison. Only one of the residents who was asked refused to participate.

Data Description

The data were derived from 15 transcribed family therapy sessions. Transcriptions produced 334 single-spaced pages with 12 point Times New Roman font. Transcribed sessions ranged from 9 to 41 pages (M = 22.27, SD = 9.54). Transcripts from explore phase sessions ranged from 21- 41 pages (M = 29.25, SD =9.95). Apply phase transcripts ranged from 12 to 27 pages (M = 16.80, SD = 6.22). Transcriptions from the impact phase sessions ranged between 9 and 21 pages (M = 17.00, SD =5.66), and transcripts from the two test phase sessions were 27 and 38 pages (M = 32.50, SD = 7.78).

[15] Each Sunday morning RTC residents are asked to fill out a standardized questionnaire regarding their perceived therapeutic status. I used this designated time for the distribution of this investigations questionnaire to remain within the constraints of the resident's daily routine as much as possible.

Data Analytic Procedures

ATLAS.ti, a software package that allows for centralized and paperless storage, editing, and retrieval of qualitative data was used to handle the difficult task of managing transcripts from the 15 therapy sessions. This software was used to organize the accumulated memos, notes, and codes inherent in a grounded analytic process. As described by Weitzman (2000), this product helped with speed, consistency, representation, and consolidation, but it did not and could not substitute for the inferential and interpretive work necessary in drawing conclusions about the quality and character of the data. In what follows, I walk through the steps I took to develop an interpretation of the discussion of emotion during these family therapy sessions. It should be noted that the actual process was less linear in practice than is described here.[16]

Data Organization and Reduction

According to Marshall and Rossman (1999), the common thread among approaches to and phases of qualitative data analysis is that "[e]ach phase of data analysis entails data reduction as the reams of collected data are brought into manageable chunks…" (p. 152). In fact, the process of reduction really begins before the data are even collected. Wolcott (1982) argues that it is "…impossible to embark upon research without some idea of what one is looking for and foolish not to make that quest explicit" (p.157). Wolcott's sentiment points to the necessary trade offs in determining the focus or boundaries of qualitative data collection and analysis. Given the exploratory nature of this project, one might expect a rather loosely bounded qualitative design. However, I

[16] The subtitles first, second and third read are not meant to suggest that I only read through the data three times. Each "read" included several passes through a given transcript. The subtitles offer a simple way to organize the description of the process.

agree with Miles and Huberman (1994) who suggest that tighter designs can be particularly useful where a researcher is "…working with well delineated constructs" and/or "…the researcher has an idea of the parts of the phenomenon that are not well understood and knows where to look for these things – in which settings, among which actors" (p. 17).

In this case, as has been argued above, Emotion Regulation Theory (ERT) provides a clear conceptual framework for meta-emotion philosophies but offers only limited clarity regarding the details of observing those philosophies being enacted in ongoing interaction. On the other hand, the theory does direct attention to the appropriate actors, behaviors, and settings for identifying MEBs. In combination with my experiences as an employee of the RTC, analyses were in part guided by the existing literature on ERT (Gottman, et al., 1997), emotion prototypes, (Shaver, Schwartz, Kirson & O'Connor, 1987) and emotional competence, (Saarni, 1999).

First Read

Upon retrieval of the transcribed family therapy sessions, I began analysis by simply reading and listening to the recordings. One of the advantages of using the ATLAS.ti software was the ability to manipulate and record in memo form comments regarding the text. As I read and listened to the recordings, I opened and began entering comments into memos that I titled First Read, along with the transcript code by phase and family number (e.g., First Read MA-1). These memos were "attached" or linked to each transcript, respectively. Initial memos helped to point out important methodological issues to be aware of including the complicated nature of tracking participants' emotions

about their emotions and moments when participants stated that they were experiencing multiple emotions at once. These early readings provided a sense of the amount and quality of the data that had been collected and helped to provide context for the first steps in the process of open and in vivo coding (Strauss & Corbin, 1998).

Second Read

I purposely avoided linking codes to the data during the first read to be sure that I was not overlooking important points by adhering too closely to the existing theoretical literature. I wanted my successive passes through the data to be unencumbered by "theoretical blinders." During my second pass through the data, my goal was to identify what I have referred to as emotion statements and to track the use of emotion terms by the participants.

Emotion Statements

In ATLAS.ti and on paper copies of the transcripts, I identified 362 emotion statements via iterative readings of the 15 transcripts. Emotion statements were conceptualized as the explicit expression or declaration of a past, present, or future emotional state by any participant in the recorded family therapy session followed by an implicit or explicit response by any other participant. Given the dynamic nature of live interaction, statements included single emotions from single participants and/or multiple emotions from various participants. The beginning and/or end of a given statement was indicated by speech turns that led to the discussion of a new emotion or emotional state. Emotion statements were labeled or coded generically as an "emotion statement": no

statement was linked with an emotion; making these links was left for the content analytic coding performed later.

When multiple emotions were included in a single statement, it was often for one of three reasons. First, it was relatively common for participants to express an emotion about their own emotion (e.g., Resident from Apply Family 2 stated: "It's stupid. I'm angry that I'm feeling angry. I'm frustrated with myself because I shouldn't…shouldn't …I shouldn't be feeling that way"). The second common case of multiple emotions in a single episode occurred when participants responded to anothers' emotion by expressing their emotion (e.g., Father from Explore Family 3 stated "Well, it hurts me to hear you say, 'Oh, I'm really sad, but it's not about you people'"). Finally, it was also common for participants to provide hypothetical and/or past experiences as examples in their discussion of a participant's "typical" emotional behavior where the characters in the shared story were said to have experienced/expressed a particular emotion, and the storyteller shared his or her emotional reaction to that story or character (e.g., Therapist working with Test Family 1 shared this example "…so if I talk to my wife about going to Hooters and she expressed her feelings and, and there's some chance that I might go away with some resentment and say 'man, ball and chain, won't let me do anything with the boys'…").

These emotion statements were later subjected to content analyses, described below. During that process, there were 11 instances where either the trained coder or I found it necessary to adjust the length (3), discard, (3) or break a single statement into two or more shorter statements (5). In each case, the final adjustments were decided via discussion. All other statements were retained as initially coded resulting in a total of 370

emotion statements. It is important to note that I did not look at emotional statements holistically in this round of analysis. My aim in this pass through the data was to create a focused view on specific opportunities for responding to emotion so that they could be content analyzed. In subsequent, more broadly focused passes, several related emotion statements were included in what I described as emotion discussions or expressions. In this way, I moved between the specific and the general zooming in and out on the data to help illuminate convergences and discrepancies in my thinking. I will describe this in further detail below.

Statements per transcript ranged from 5 to 51 (M = 24.67, SD = 11.55). Emotion statements ranged in length from a single line of text to 84 lines (M = 13.14, SD = 11.59). Statements were distributed across the stages of intervention as follows: explore transcripts (4) produced 144 total statements ranging between 25 and 51 per transcript (M = 36.00, SD = 10.96), apply transcripts (5) produced 98 statements ranging between 10 and 32 per transcript (M = 19.60, SD = 8.65), the impact transcripts (4) produced 73 statements ranging between 5 and 31 per transcript (M = 18.25, SD = 10.69), and the test transcripts (2) produced 55 statements, one with 23 and the other with 32 (M = 27.50, SD = 6.36).

Emotions

At the same time that I was scanning the transcripts for emotion statements, I was marking emotion terms used by the participants using the in vivo tool provided by ATLAS.ti. This tool allowed me to simply highlight the emotion term used by participants and instantaneously create a new code. The system recognizes exact

redundancies and tracks frequencies automatically. However, similar but not exact matches required me to assess and merge codes at the conclusion of this pass through the data. In addition, the software allowed me to create Prototype "families" of emotion terms. This feature later helped in calling up participant responses in conjunction with particular emotion families or prototypes. This aided in the process of constant comparison, a technique that was woven throughout the analytic "steps." Two hundred eight grounded emotion terms were identified via "in vivo" coding during the reading of the transcripts. The grounded terms are outlined and discussed in Chapter VI.

Content Analyses

After the emotion statements were identified in ATLAS.ti, I indicated their positions on paper copies of the transcripts by highlighting in pink marker the beginning and bracketing the ends in pen. The statements were then deductively coded following traditional content analytic procedures. This systematic approach to the data offered an appropriate way to address this investigation's research questions regarding the frequency and potential relatedness of therapeutic issues discussed and emotions elicited across the RTC phases. As indicated above, transcripts averaged 25 statements each, ultimately producing 525 "texts" for analysis. Units of analysis within the texts were both physical (e.g., source and target) and referential (e.g., emotion and task). More specifically, with the aid of a second trained coder, I identified: (a) the expression of an "emotion" in a given speech turn, (b) the individual emoting, or the "source" of the emotion, (c) the "target" of the emotion (e.g., person, place, thing), and, (d) the therapeutic issue, topic or

"task" related to the expression of the emotion. Operational definitions and examples are provided below.

Emotion Prototypes

Fehr and Russell's (1984) often cited quip "[e]veryone knows what an emotion is, until asked to give a definition" (p. 464) highlights the difficulty in establishing a precise definition or, in this instance, clarity regarding inclusion/exclusion rules for what constitutes an emotion. One practical solution to this problem was to draw on Shaver, Schwartz, Kirson, and O'Connor's (1987) prototypes for emotion words. Their work categorizes 135 specific emotion words in American English into 6 empirically derived clusters of emotion prototypes: love, joy, anger, sadness, fear, and surprise. According to Shaver et al. (1987), each of the prototypical emotion categories includes a family of more specific emotional states. For example, the anger prototype includes rage, irritation, frustration, jealousy, and a number of other specific emotions. The sadness prototype includes agony, suffering, hurt, anguish, and hopelessness among others. The coding of emotions from the emotion episodes was in accordance with the Shaver et al. prototypes model.

The coder and I agreed to categorize emotion words that fell outside of those accounted for in the Shaver et al. model (e.g., "Selfish," "Shitty," "Stressful," "Independent," "Solid") based on contextual referents. In instances where contextual referents failed to provide enough evidence, or evidence suggested that the emotion fell outside of the prototypes model, the coder and I agreed to use the "other" category and to list the term in the space provided on the code sheet. Discrepancies were negotiated

between the coders. Terms used that expand on the Shaver et al. categories are provided and discussed in Chapter VI.

Sources and Targets

For this investigation, a "source" was conceptualized as any party named within an emotion statement who expressed an emotion explicitly or who was described as the expressor of an emotion by any other party. As such, a source could identify him or herself (e.g., "I am really angry right now") or be identified by an other (e.g., "You can't see this at home Mom and Dad, but Andy is really angry right now"). Potential sources of the emotions under discussion were each of the parties present in the room (i.e., mothers, fathers, residents, therapists). In addition, however, it was considered equally likely that emotions discussed during the "emotion statements" came from sources outside the immediate group (e.g., Andy, your brother Dan is really angry with you). In an effort to address this possibility, I included RTC staff, resident peers, siblings, friends from home, and "others" among possible sources of emotion who are not likely to be present in the sessions.

Similarly, "targets" of emotions were defined as those parties explicitly/implicitly named within the emotion statement as the "reason for" or "recipient" of a particular emotion. Like the source, potential targets may or may not have been physically present at the recording of the therapy sessions. Potential targets included all parties present at the recording, RTC staff, RTC peers, siblings, friends from home, the home "situation," the RTC "situation," and "others" unforeseen. The "situational" categories were meant to reflect likely but indiscernible individual targets as in, "I hate being here" (i.e., RTC

situation), or "I'm angry that our family treats Emily [my sister] so poorly " (i.e., home situation). Again, discrepancies were negotiated between the coders.

Therapeutic Tasks

To address the relationship between particular emotion prototypes and the therapeutic tasks at hand, I also identified the issues discussed during the emotion episodes. To do so, the coder and I relied on the RTC's categorization system of resident issues. Commonly referred to as "vernaculars" among the facility residents and staff, the RTC Employee Handbook outlines three general and nine specific categories for naming problematic behaviors or issues to be worked on (Balmer, 2005). According Balmer, the vernaculars simplify the "…often complex psychiatric or psychological jargon into a 'user friendly,' easily understood, universal language of problems which aids in therapeutic interaction amongst peers" (p. 2).

The three broad categories of problematic behaviors are the following: inconsiderate of self (i.e., the resident does things that are damaging to the self), inconsiderate of others (i.e., the resident does things that are damaging to others), and low self-image (i.e., the resident has a poor opinion of the self, often feels denigrated or of little worth). When more specificity is needed, these broad "supra" categories are broken into nine subcategories of behavior: authority problems, misleads others, easily misled, aggravates others, stealing, alcohol or drug problems, lying, and fronting. Each of the nine specific vernaculars is defined in Table 3.

Table 3 *RTC Vernaculars and Examples*

Task	Description	Example
Authority Problems	Does not want to be managed by anyone.	"Emily has repeatedly been disrespectful to her milieu staff"
Misleads Others	Draws others into negative behavior.	"I told the new kid we could have doubles on desert"
Easily Mislead	Is drawn into negative behavior.	"Dan always seemed to let his friends get him into trouble at home too"
Aggravates Others	Treats people in negative, hostile ways.	"Your peers tell me that you purposely spray them with the window cleaner"
Easily Angered	Is often irritated or provoked or has tantrums.	"I threw the broom because I can't stand all the damn rules here"
Stealing	Takes things that belong to others.	"I needed toothpaste so I took my roommates"
Alcohol or Drug Problems (CD)	Misuses substances that could hurt self.	"My peers keep talking about using drugs at home, and I am having cravings"
Lying	Cannot be trusted to tell the truth.	"Your last urine test proved that you can't be trusted"
Fronting	Puts on an act as opposed to being real.	"I laugh when dad says those things so we don't have to talk about it"

The coder and I agreed to utilize the more specific behavior categories whenever possible. There were two noted deviations from this procedure. In instances where the therapeutic task was ambiguous, the coder and I used contextual referents to select a supracategory. Secondly, there were instances when there seemed to be a specific therapeutic task under discussion, but that task did not fit neatly within the RTC vernaculars model. In these cases, the coder and I agreed to select the most appropriate supracategory and name the task in the "other" space provided on the code sheet.

The coder and I worked through approximately 15% of the emotion statements independently for an initial check on intercoder reliability. Together we achieved .73 simple agreement and our agreement corrected for chance, Cohen's Kappa (k = .67). An acceptable level of agreement corrected for chance is .70. As such, discrepancies were negotiated collectively, refinements to the categories and coding rules were made, and a second round of coding including 15% of the remaining data was checked for reliability. In the second round of coding, our simple agreement was .85 (k = .83). Given the improved reliability, I coded the remaining transcripts alone, recorded the codes on the standardized Emotion Statement Code sheets (see Appendix E), and entered them into the Statistical Package for the Social Sciences program for more detailed analysis via contingency tables. These tables are presented and discussed in the subsequent chapters.

Third Read

Although the content analytic process produced only frequencies of occurrence, the data helped to provide a clearer picture of the participants, the salient emotions, and the tasks at hand during the therapy sessions. With each step in the process, I was

becoming more immersed and engaged with the texts. The content analysis allowed for a focused view of small segments of the transcripts. It became clear to me during this process that, not surprisingly, the resident was at the center of most of the emotional discussion. Importantly, however, there were also instances to be analyzed where parents and even the therapists expressed emotions that were responded to by the residents and each other.

I noted in a memo that elements of meta-emotion philosophy could be spotted rather easily in the passes through the transcripts and that although the emotion statements provide "clean" moments in the discussion for analysis, the quality of responses to expressed or discussed emotions required a broad and potentially "messier" perspective. Whereas emotion statements had been punctuated by a "new" emotion, I would begin to look at the transcripts more episodically, for lack of a better term. For me, this meant reading and listening again to the recordings so that I could piece together a primary emotional current that ran through a sequence of turns, even where new or differing emotions were named by the source. This also meant tracking the ongoing response(s) to that emotion over larger portions of the transcripts. Rather than overlaying these expanded excerpts from the transcripts on the existing ATLAS.ti files, I decided to open a new file with clean copies of the transcripts.

Analyses at this step in the process unfolded first descriptively, using a provisional start list of codes, and then interpretively, weaving together notes and pattern codes culminating in the identification of recurring themes in reflective memos. As was suggested by Miles and Huberman (1994), I used a start list of codes derived from the existing literature on the behaviors Gottman (1997) suggests are constitutive of meta-

emotion philosophies. These codes were held loosely through the readings of the transcripts and document notes, and they provided a conceptual focus reflective of the driving research questions.

Using the memo function within the ATLAS program, I was able to open and add to memos I classified as "commentary," "methodological," or "theoretical" depending on their purpose. Commentary memos took the place of traditional marginal notes. Methodological memos allowed me to track changes in my conceptualizations, codes, patterns, and themes. Finally, theoretical memos helped to note links and relationships across the texts. Early memos written during the data collection process noted the difference between expressions of a particular emotion and the discussion of an emotion. Expressions refer to the actual experience of an emotion in that moment of the conversation. Discussions, on the other hand, referred to emotions experienced in a past or hypothetical future situation.

In addition, these early memos captured notes which indicated that the first order codes were not so much wrong as incomplete. In subsequent passes through the data, I responded to my notes by modifying and refining the initial codes so that they became more particularly linked with chunks of data. The refined codes for coaching, for example, became skill specific (i.e., coaching awareness, coaching self-regulation, etc.). The identification and utilization of these more refined codes clarified for me the multifaceted nature of each speech turn. That is, as we know, utterances carry with them both content and relational meaning. What became increasingly apparent was that the speech turns seemed to offer different relational meanings for each of the participants (e.g., advice offered up explicitly to one member of the group was also modeled for and

implicitly directed toward each of the other members of the group). My next step was to try to provide a more broad or macro level assessment of how this process works.

In iterative passes through the transcripts and document notes, I moved between commentary and theoretical memos to make sense of larger patterns in the data. I attempted to subsume the particulars identified with the first order codes into a more general understanding of the processes at work. In memo form, I summarized those patterns into codes (e.g., *confirmatory listening* as a speech act demonstrating that one has heard and understands the other, or *open advising*, as advise giving qualified by space for the recipient to accept, reject or modify its applicability). I used these pattern codes to compare and contrast emergent themes across cases (or in this instance across and among RTC phase groups). This constant comparison allowed for a check on theoretical biases by subjecting the codes to qualification against potentially rival explanations (Miles & Huberman, 1994): moreover, these authors also suggest that the identification of themes across cases allows for powerfully situated explanatory claims.

Holding the pattern codes to the data provided a lens through which I was able to see strong conceptual relationships between the overarching meta-emotion philosophies and the communicative behavior enacted by the participating families and therapists. Specifically, it became evident that the family therapy sessions simultaneously provide a teaching/learning/testing ground for expressing and responding to one another emotionally.

Having used the pattern codes as a check against divergent explanations, I felt comfortable that I could provide a coherent interpretation of the communicative processes I observed. In a theoretical memo referencing the emergent themes in the data,

I began to build a logical chain of evidence in support of claims regarding the quality and character of Meta-Emotion Behavior (MEB) during adolescent male family therapy sessions. I have used the research questions posed above to frame the structure of my discussion below.

CHAPTER IV

THE EMOTIONAL PROFILE OF ADOLESCENT MALE FAMILY THERAPY SESSIONS

The primary concern of this investigation has been to document the response to and discussion of emotion during family therapy sessions with adolescent males. To do so it was important to first determine and describe the emotional profile of these sessions. Four of the research questions posed in Chapter II were directed at doing just that. Research Question 3 asks: What emotions are salient during family therapy sessions across phases of therapeutic intervention for adolescent males? Research Question 5 works as an important follow-up by asking whether differences exist in expressed emotion at each phase. And, Research Questions 7 and 8 look at the relationship between therapeutic tasks and emotion. Frequency and Contingency tables are used to provide evidence for the claims and interpretations that are offered below. Chi-squares for the contingency tables are not reported here because the data violate the assumption of independence. I begin with a brief discussion of the range of terms used to express emotion.

The Range of Emotion Vocabulary

The first step in answering Research Question 3 was to document the range of the participants' emotion vocabularies. I did so by recording the terms actually used by

participants during the therapy sessions to describe how they felt. The coding resulted in the 208 grounded terms presented in Table 4 according to their prototype. Examination of the table below reveals that the majority of the terms used by participants seem to reflect variations in the intensity of the prototype terms (e.g., calm and excited fall within the joy prototype). A great deal of specificity is lost when the terms are compressed into their prototypes. Many of the grounded terms provide something of an embedded script for action and help to identify the source or target of a given emotion during communicative episodes. The term "blessed" for example indicates a positively valenced accounting of an individual's life and/or accomplishments.

Several terms were used to reflect emotions that do not necessarily fit as typical emotion words. Their inclusion here is based on the phrasing used by participants. In most cases this means that the terms were prefaced with "I feel…," "It makes me feel like…" or are direct responses to the question, "How does that make you feel…?." I am not making the argument that these terms are emotions, but rather that they functioned in these conversations as emotion-like terms and were reacted to by other members of these family therapy groups as though they were emotions. I included them because they are relevant to understanding the enactment of Meta-Emotion Behavior.

One grouping of emotion-like terms included in the table above can be described as slang. Not surprisingly, participants used terms such as, "pissed off," "ticked off," "shit," "freaking out," "flipping out," and "crappy." Each of these terms was fairly easily linked with either anger or sadness based on contextual cues and common usages.

There were also groupings of self-implicative terms used as and related to emotions. Participants used the terms "self-confidence," "self-interest," and "self-worth"

Table 4 *Grounded Emotion Terms According To Prototypes*

Love	Joy	Surprise	Anger	Fear	Sadness	
care	amazed	shock	accusatory	afraid	alienating	let down
connection	appreciate	surprised	aggravation	anxiety	ashamed	like a real
love	awesome		anger	apprehensive	bad	jerk
spirituality	blessed		animosity	avoidant	belittled	lonely
touching	calm		annoyed	awkward	betrayed	loss
yearning	centered		badgered	codependent	bummed	miss
	comfortable		bigger than	concern	crappy	mistreated
	confidence		bother	confused	defective	needy
	considerate		bugged	creepy	depression	not feel
	cool		destructive	defensive	didn't care	not good
	curious		didn't like	disconcerting	different	offended
	enjoy		disrespectful	distraught	disappointed	overwhelmed
	even keeled		edgier	doesn't feel	disconnected	playing the
	excited		explode	right	dishonoring	victim
	feel better		flipping out	fear	distant	pointless
	feel good		frustration	freaked out	distracted	put down
	fine		gets under	lack of trust	down	regret
	fun		my skin	nervous	drained	remorse
	giving a damn		gristle	obsessive	dreadful	sadness
	glad		grit my teeth	on guard	embarrassed	shame
	grateful		hate	panic	empathy	shit
	happy		hot	paranoid	failed	sick
	high		irritable	powerless	feeling like a	sorry
	hope		jealousy	rattling	crackhead	sorry for
	impressed		loathing	scared	forgiveness	myself
			mad	skeptical	funks	stupid

Table 4 *continued*

Love	Joy	Surprise	Anger	Fear	Sadness	
	independence joyful liked looking forward okay pride real recognized relief resolved respected satisfied secure sincerity strong thankful thoughtful trusted welcome		on my back on my nerves ornery mood pissed off pressured rage repugnant resent spite stewing stressed out ticked off turns your gut unhappy unjustly accused upset	tentative uncomfortable weary worried	giving up got to me guilt gut it homesick horrid hurt inadequate insecure insult irrational	sucked sulking sullen sympathy tired turns your gut ungenuine upset used weak weird woes yucky

in reference to experiencing love or pride in oneself. Others used "self-confidence," "self-pity," and "self-defeating" in the expression or discussion of sadness, feeling down, unwanted, or alienated. Still others used the words "selfish," "entitled" and "spoiled" to describe the way they "felt" at a given point in their life. These expressions were difficult to pin to down to any particular emotion prototype and were, therefore, left out of Table 4. Other terms difficult to pin down and closely linked with the self-implicative grouping are "self-harm" and "suicidal" thoughts and feelings. Residents variously described suicide and self-harm as a release from feelings of deep depression and self-loathing. Consider this exchange between a distraught resident and his therapist.

> Therapist: "Is it difficult for you to be experiencing this right now?"
>
> Resident: "Extremely."
>
> Therapist: "Okay. So those thoughts of self-harm? Are you having thoughts of self-harm or suicide or both?"
>
> Resident: "Both."
>
> Therapist: "Okay. Is that because that would provide an outlet, a release?"
>
> Resident: "Yes."
>
> Therapist: "A way for you to not feel this anymore?"
>
> Resident: "Not feel the hate? Yes."

Here the emotion is actually "hate" and self-harm or suicide are described as emotion regulatory tactics. Ultimately these emotion-like or emotion-related terms are responded to in ways that inform our understanding of emotion coaching and/or dismissing.

Participants who struggled to find more prototypical terms for emotion often used words or phrases that suggested an embodied or visceral experience: "turns your gut,"

"guttin it," "on my back," "on my nerves," "grit my teeth," and "under my skin." In the example provided below, the therapist struggles to get the resident to use prototypical emotion vocabulary; instead the resident uses terms that describe physical sensations.

> Therapist: "Um, and so when you interact with [Staff A] you feel like he's on your back? Can you describe the feeling or feelings that better describes like being on your back?"
>
> Resident: "Um. I don't know if this has anything to do with it, but the first thing that popped into my head was - rushed."
>
> Therapist: "Rushed?"
>
> Resident: "Yeah. I don't think that has anything to do with it?"
>
> Therapist: "Pressure?"
>
> Resident: "Yeah, that's a good one. Pressure. I mean, I know it's stuff that I have to do. It's like, I mean, when [Staff A] is always on my back like I feel pressured because not only is he telling me to do something, but other people are. So, then I'm like kind of being pushed from two sides to like one direction and it doesn't really work for me, so I kind of, I guess, clam up."
>
> Therapist: "Okay."

One possible explanation for this resident's reluctance to use more prototypical emotion terms is that he has a limited range, or that his repertoire of terms is underdeveloped. Another explanation is that he incorporates his physiological experiences into his expression of emotion. Perhaps the prototypic emotion terms do not capture the experience well enough for the resident, prompting him to explore more creative ways to express himself. Whatever the case, those who respond to this resident and others like him are charged with interpreting his emotional experience without the aid of prototypical terms and must, therefore, be prepared to attend to contextual cues to offer relevant feedback.

The accounting of these emotion and emotion-like terms helps to provide a clear picture of the emotional exchanges recorded during these family therapy sessions. It seems clear that a variety of terms were used to express emotion at varying degrees of intensity. In most cases, the terms used by the participants were easily categorized within the prototype system developed by Shaver et al. (1987). Although, as indicated above, a considerable amount of specificity is lost in the reduction of data, I will be using the prototypes as indicators of the emotion under discussion for the remainder of this document. I turn now to discussing the results of analyses used to answer Research Question 3 more directly.

Prototype Salience

Content analyses condensed the grounded terms into the emotion prototypes developed by Shaver et al. (1987). Table 5 outlines the frequency of all prototypes across the stages of intervention and by participating resident. Nearly three quarters of the coded emotions fell within the Joy (n = 129, 25%), Sadness (n = 122, 23%), or Anger prototype (n = 119, 23%). The remaining emotions were distributed as follows: Fear (n = 71, 13%), Love (n = 59, 11%), "Other" (n = 17, 3%) and Surprise (n = 8, 1%). The "Other" category included terms such as; "Emotion(s)," "Feelings," "Comfortable," "Suicidal," "Feelings of Self-harm," "Like a Crackhead," "Like an Idiot," "Selfish," "Stressful," "Independent," and "Solid." The "Emotion(s)" and "Feelings" terms occurred several times and contextual cues indicated a mixture of anger and sadness as the basis for the term. The relative scarcity of occurrence of the Surprise prototype across all transcripts warranted its collapse with the 'other' category for the remaining assessments.

Table 5 *Frequency of Emotion Prototypes by Resident and Phase*

	Explore				Apply					Impact				Test		
	1	2	3	4	1	2	3	4	5	1	2	3	4	1	2	Totals
Love	8	6	1	3	0	14	2	4	2	6	3	3	2	4	1	59
Joy	7	29	12	13	8	6	1	7	7	3	3	4	6	9	14	129
Surprise	0	1	0	0	0	0	0	0	1	0	4	0	0	0	2	8
Anger	6	9	20	1	12	19	13	3	1	5	3	0	8	13	6	119
Sadness	8	15	17	11	4	12	10	1	11	9	6	0	14	3	1	122
Fear	8	8	4	13	1	3	5	1	2	7	4	0	10	1	4	71
Other	0	1	1	2	1	1	1	0	1	2	0	0	0	4	3	17
Totals	37	69	55	43	26	55	32	16	25	32	23	7	40	34	31	525

Interestingly, Joy terms occurred with almost the same frequency as terms indicative of the anger and sadness prototypes. The research reviewed regarding adolescent emotions suggested that their experiences were negatively skewed toward sadness in particular (Larson, 1991).

As will be discussed below, given that residents were the source of emotion most of the time, one might have expected that Joy terms would have occurred less frequently. Undoubtedly, parents and therapists expressing their hopes for the future and pride in achievement helped to boost the relative frequency of the Joy prototype, but the presence of these terms and this emotion in the recorded discussions is important nonetheless. Just as sadness and anger can be responded to in ways that demonstrate coaching or dismissing behavior, so too can joy.

The collapse of the Surprise prototype was somewhat expected given similar results reported by Shaver et al. (1987). One potential explanation for this result is that although this emotion seems at first glance to stand alone, it might better be described as diffuse. Surprises can be joyful (e.g., a birthday party), fearful (e.g., being approached by a stranger), angering (e.g., finding that one has been swindled), and even saddening (e.g., the sudden death of a loved one). The emotional response to a surprise is probably as relevant to the issue of Meta-Emotion Behavior as is the initial surprise and probably more apparent.

As an initial response to Research Question 3, the data seem to suggest that Joy, Anger, and Sadness are the most salient emotions during family therapy sessions with male adolescents. Whether these are the emotions most often responded to in a coaching or dismissing manner is an issue discussed in Chapter V. For now it is sufficient to say

that these results suggest looking beyond Anger and Sadness and point to the next logical step in expanding our understanding of Meta-Emotion Behavior. When it comes to considering Meta-Emotion Behavior in the context of family therapy, emotions like Fear, Love, and Joy should be considered. I turn now to discuss differences in the expression and discussion of emotion across the phases of intervention.

The Question of Difference

Research Question 5 asks whether emotions expressed differ according to stage of intervention at the RTC. A 4 x 5 contingency table analysis was conducted to evaluate the salience of emotion prototypes (i.e., Joy, Anger, Sadness, Fear and "Others") during family therapy sessions at each of the therapeutic stages of intervention (i.e., Explore, Apply, Impact, and Test). Table 6 indicates, by frequency and percentages, the emotion prototype discussed most often within each phase of intervention after collapsing the Surprise category.

Results by Phase

The contingency table results indicate that participants in the Explore phase were most likely to discuss Joy. In fact, nearly a third of the emotions discussed during these sessions fell within the Joy prototype. This result may be linked with discussion about the hopes of each party for the resident's future. This was true in explore session two which, as indicated above, had the highest frequency of occurrence. Here the majority of the discussion was focused on the resident's plans for the future and what would constitute an enjoyable life. It may be true that one place to begin the therapeutic process is to

Table 6 *Frequency of Emotion Prototypes by Phase*

	Joy	Anger	Sadness	Fear	Love	Other	Totals
Explore	61	36	51	33	18	5	204
*	(29.9)	(17.6)	(25.0)	(16.2)	(8.8)	(2.5)	
Apply	29	48	38	12	22	5	154
*	(18.8)	(31.2)	(24.7)	(7.8)	(14.3)	(3.2)	
Impact	16	16	29	21	14	6	102
*	(15.7)	(15.7)	(28.4)	(20.6)	(13.7)	(5.9)	
Test	23	19	4	5	5	9	65
*	(35.4)	(29.2)	(6.2)	(7.7)	(7.7)	(13.8)	
Totals	129	119	122	71	59	25	525
**	(24.6)	(22.7)	(23.2)	(13.5)	(11.2)	(4.8)	(100)

*(%) Within Phase
**(%) of Total

explore short and long term goals for progress. It is important to note that Sadness is the second most prevalent emotion during the explore phase. Perhaps discussions about the pursuit of happiness become exaggerated to counteract the Sadness expressed by residents who have been removed from their homes and are confronted with the prospect of a long term stay at the RTC.

More than one-third of the emotions discussed during the Apply sessions fell within the Anger prototype. Recall from the description of the Apply phase that residents are expected to take on more responsibility within their community and to demonstrate their newly adapted skills. The pressures associated with advancing to this phase may also trigger frustrations. Here the resident is beginning to operate within a system that challenges old patterns of behavior that are comfortable and reliable even if ineffective. In addition, it was common for both therapists and parents to relate day-to-day frustrations at the RTC with the experience of similar issues at home.

Participants in the impact phase talked about Sadness more than any other emotion. Expressions of regret from both parents and residents are likely explanations for this result. The transcripts revealed parents and residents who were accepting responsibility for their contributions to their poor relationships. It was common for participants in this phase to take up the topic of reconciliation offering apologies and expressions of remorse. Residents were also open about experiencing a sense of lost time at home with friends and family.

Finally, participants in the Test sessions, like those in the Explore phase, talked more about Joy than any other emotion (35.4%). While it is difficult to draw conclusions based on only two sessions, it seems reasonable to think that upon reaching the Test

phase, residents and parents return their conversations to short and long term goals regarding the resident's graduation from the RTC. In fact, the discussions recorded by these two families were almost exclusively focused on immediate plans for the future and conveyed a general sense of satisfaction with their progress.

Results by Emotion Prototype

Close examination of the table reveals that each of the prototypes was most likely to occur in either the Explore or Apply phase sessions. Participants in the Explore phase sessions accounted for 47% of all Joy expressions, 46% of all Fear expressions, and 41% of all Sadness expressions. In the Apply phase, participants accounted for 40 % of all Anger expressions and 37% of all Love expressions. Claims that the Explore and Apply phase sessions are the most "emotional" based on these numbers have to be tempered by the fact that there were 5 families included in the Apply phase, and only two families in the Test phase group; however, the 4 families included at the Explore phase demonstrate a significant majority in both raw frequency and in percentage of total expressions for three of the five emotion prototypes. This finding lends credence to a claim that there is a significant break in participants' emotional expressions between the Apply and the Impact phase of intervention

Sources of Emotion

To provide additional clarity regarding the expression of emotion during the recorded therapy sessions, contingency tables were produced to delineate which participants were most often the source of emotion. Table 7 provides a breakdown of emotion prototypes by the source (i.e., expressor) of the emotion. As indicated in the

Table 7 *Collapsed Prototypes and Sources of Emotion*

	Resident	Therapist	Father	Mother	Parents	Other	Totals
Love	27	0	9	8	10	5	59
*	(45.8)	(0)	(15.3)	(13.6)	(16.9)	(8.5)	
Joy	58	13	18	13	19	8	129
*	(45.0)	(10.1)	(14.0)	(10.1)	(14.7)	(6.2)	
Anger	86	5	7	4	5	12	119
*	(72.3)	(4.2)	(5.9)	(3.4)	(4.2)	(10.1)	
Sadness	78	0	7	17	7	13	122
*	(63.9)	(0)	(5.7)	(13.9)	(5.7)	(10.7)	
Fear	48	8	5	5	5	0	71
*	(67.6)	(11.3)	(7.0)	(7.0)	(7.0)	(0)	
Other	19	0	2	1	1	2	25
*	(76.0)	(0)	(8.0)	(4.0)	(4.0)	(8.0)	
Totals	316	26	48	48	47	40	525
**	(60.2)	(5.0)	(9.1)	(9.1)	(9.0)	(7.6)	

*(%) Within Prototype Category
**(%) of Total

Methods chapter of this document, coders were provided 11 possible sources of emotion (i.e., Resident Male, Resident Female, Therapist, Father, Mother, Sibling, Resident Peer, Home Peer, RTC Staff, Parents, Other).

Frequencies warranted retaining 5 of the original 10 substantive categories and collapsing 5 more into the "Other" category. Not surprisingly, those who participated directly in the therapy sessions (i.e., Resident, Therapist, Father, Mother, Parents) accounted for more than 92% of all sources of emotion. The table indicates that in the majority of cases (60%) the resident was coded as the source of the emotion being tracked. And, consistent with the frequencies reported for the general tracking of emotion, residents were most likely to express Anger (27%), Sadness (25%), or Joy (18%).[17] This suggests, of course, that the resident is the likeliest target for either coaching or dismissing responses during the therapy sessions. This issue is discussed in Chapter V.

Parents were the second most likely source of emotion. Mothers (9%), Fathers (9%), and "Parents" as a single entity (9%) were equally likely to express emotion. Like the residents, parents expressed emotions reflective of each of the prototype categories, but they differed on which emotions they expressed most often. Fathers expressed Joy most often (37%), followed by Love (19%). Mothers expressed Sadness most often (35%), followed by Joy (27%). When parents were considered a single entity, they expressed Joy (40%) and Love (21%) most often. The positive skew to parents' expressed emotions may help to explain the prevalence of Joy in the Explore phase,

[17] Column percentages calculated by hand and not included in the table.

particularly when it is taken into account that the highest percentage of all emotions were expressed during that phase.

The tendency of mothers to express Sadness more often than other emotions is somewhat difficult to explain. There is some evidence to suggest, however, that mothers were treated differently than fathers by their adolescent sons. That sentiment is reflected well in the following excerpt.

> Therapist: "Do you treat one parent better than the other, or do you blame one parent for the divorce?"
>
> Resident: "Right. Um, to address the first question, I have to say, uh, when I'm around dad I'm a little bit more careful of the way I hold myself or represent myself. I try to, uh, come off as a little more mature than I am around my mom. Um, but…"
>
> Therapist: "Why? Why do you feel you need to be more careful or watch yourself more around your dad than your mom?"
>
> Resident: "I wouldn't say watch myself as much. Uh, I feel that my dad is, uh… that it's important for him to know that I can act my own age."
>
> Therapist: "It's not important for your mom?"
>
> Resident: "Not necessarily. I feel like, um, just a little bit more casual around my mom. Not that I'm not casual around my dad either, I do joke around about some things with dad that I wouldn't necessarily joke about with my mom, um… As far as treating them differently, I have to say the majority of the time I spend with my dad, uh, as opposed to the time I spend with my mom, I do try to present myself with a, just a little bit more gracefully, for lack of a better term. Um… when I'm around my mom I'm just kind of, you know, foolish. I try to be… when I do get serious, it seems like the times I'm serious are the times that I'm angry. Ah… although in events that are coming up that are pretty big, like [Sister's] wedding for example, uh, I thought like I could be serious around my mom too. The reason I joke off a lot of things with my mom is because probably it gives me something to fall back on when I get angry with her. I can just joke it off."

One possible explanation for the occurrence might be related gender effects. That is, perhaps roles would be reversed if this study included adolescent females. Although this explanation reveals a weakness of this investigation, it also offers a clear direction for future research.

The therapist was the participant least likely to express emotion (5%) during these sessions. Therapists were recorded to have expressed Fear, often as concern for the resident's future based on current decisions or attitudes held by the resident. Therapists expressed Joy, often as gratitude or praise for either the parents or the resident. Finally, therapists expressed Anger during the sessions often as frustration with the resident's behavior both inside and outside of the current session.

Sources coded under the "Other" category prior to merging the low frequency substantive categories, fell within three groupings; Specific Examples (e.g., Hitler, a waitress from home, a peer's parents, past residents, a home acquaintance, and the therapist's wife), Hypothetical or Generalized Others (i.e., unspecified others as an example), and The Family Group (i.e., the parents' and the resident's shared emotion).

Targets of Emotion

The targets (i.e., reason for or recipient of the expressed emotion) were tracked as well. Table 8 illustrates the results of a 6 x 6 contingency table containing the retained emotion prototypes by a collapsed group of targets. Six of the original 12 substantive target categories were retained while the remaining six – Therapist, Mother, Sibling, Resident Peer, Home Peer, and RTC Staff – were collapsed into the "Other" category based on their low frequencies of occurrence. Again, the residents (42%) were the most

Table 8 *Collapsed Prototypes and Targets of Emotion*

	Resident	Father	RTC Situation	Home Situation	Parents	Other	Totals
Love	32	5	2	1	5	14	59
*	(54.2)	(8.5)	(3.4)	(1.7)	(8.5)	(23.7)	
Joy	64	5	7	9	9	35	129
*	(49.6)	(3.9)	(5.4)	(7.0)	(7.0)	(27.1)	
Anger	28	12	8	7	20	44	119
*	(23.5)	(10.1)	(6.7)	(5.9)	(16.8)	(37.0)	
Sadness	59	6	5	12	10	30	122
*	(48.4)	(4.9)	(4.1)	(9.8)	(8.2)	(24.6)	
Fear	28	1	6	4	5	27	71
*	(39.4)	(1.4)	(8.5)	(5.6)	(7.0)	(38.0)	
Other	10	0	2	4	4	5	25
*	(40.0)	(0)	(8.0)	(16.0)	(16.0)	(20.0)	
Totals	221	29	30	37	53	155	525
**	(42.1)	(5.5)	(5.7)	(7.0)	(10.1)	(29.5)	

*(%) Within Prototype Category
**(%) of Total

likely to be coded as targets of emotion. The emotions most likely to be brought about by these targets were, again, Joy and Sadness, but expressions of Love edged out Anger and Fear as the third most likely emotion to be brought about by the resident participants.

There are three points that need to be made regarding the remaining targets. First, it is important to point out that Parents as a single entity constituted the second most prominent substantive category before the collapse of low frequency categories. It is important for mothers and fathers to recognize that their individual actions could be perceived as joined. This was true even in sessions with divorced parents. The implication is that individual responses to emotion might be considered the common stance unless otherwise specified. For example, if a mother offers a dismissive or coaching response that is not contradicted by the father, it may be taken by the resident as the accepted or common "Parents'" stance. The second important point has to do with the mother falling out of the group of retained targets. Here again, this may be a gender effect unaccounted for in these data.

Some research, for example, seems to indicate that during the process of adolescent identity development, there are significant differences in whom males and females look to for confirmation (Grotevant & Cooper, 1985). The research suggests that for adolescent girls, all relationships within the family unit are reported to be important and make significant contributions to identity development. For boys, on the other hand, their relationship with their father appears to be most important. Again, this stands as important focus for future research.

Finally, it is important to note the amalgam of "others." Prominent among the Targets coded into the "Other" category, prior to the collapsing of categories, were

instances of hypothetical persons or situations. Under this grouping of targets, participants discussed future occupations, pastimes, educational pursuits, and continued therapeutic goals, in addition to using examples of persons not yet encountered like those described by this resident.

> Resident: "Mm…I feel really confident, like I've gone over multiple situations that I'm probably going to encounter outside of [RTC] and no matter where I am. Like, I'm always going to have the people, like friends or whatever, or people around me that are trying to do what they're trying to do, and like what I have to realize is that it's their decision and like I have my own life that I want to live. If they are really a friend, they will respect the decision I make, and if they can't respect my decision, then that's not somebody I need to be hanging around with."

Like the Sources coded into the "Other" category, Targets also occurred as Generalized Examples (i.e., unspecified others) and Specific Others as Examples (e.g., a family friend, RTC Staff and Peers together, the therapist's wife, and peers' parents). Participants also named inanimate Targets of their emotion (e.g., fear of the unknown, delayed gratification, violated privacy, a new RTC, side effects from medication, restless nights, other emotions and participation in a 12-step program).

The question of difference in the expression of emotion across the phases of therapeutic intervention can be responded to with the following generalizations. It appears that there is a split between the two upper and lower phases with regard to the amount or frequency of emotion expression. The lower or earlier phases of intervention recorded more expressions of emotion than in the later or upper phases. The Explore phase in particular appears to be the most "emotional." These claims are tempered by the unequal distribution of families across the phases. Nonetheless, this finding suggests that

coaching and/or dismissing behavior may be more prevalent in the Explore and Apply phase sessions. This is supported in Chapter V.

It appears that positively valenced emotions related to the Joy and Love prototypes are just as salient as the negatively valenced emotions Anger, Sadness and Fear. Each phase, however, does appear to be characterized by a specific emotion. Residents were most often both the source and target of emotion expressions. This is not surprising given the context of these recordings. Importantly, mothers were coded as the target of emotion less than 5% of the time. This finding indicates possible gender effects and warrants further examination in future research. In summary, the results indicate that there are differences related to the emotions expressed and the source or target of the emotion across the phases of intervention. I turn now to a discussion of the therapeutic tasks addressed during these sessions.

Therapeutic Tasks and Emotion

Research Question 7 asked whether there where differences in the therapeutic tasks up for discussion during the family therapy sessions based on the phase of intervention. To begin to shed light on that relationship, Table 9 provides the frequency distribution of therapeutic tasks by phase and resident family. Recall that possible codes for tasks reflected the "vernacular" terms utilized by the RTC residents and staff. Where the "problem" or "issue" up for discussion did not clearly match one of the nine specific vernacular terms, coders agreed to choose the appropriate general term and to write in a more appropriate specific term. Based on their low frequencies, the categories, Misleads Others, Aggravates Others, Stealing and Lying, were merged with Inconsiderate of

Table 9 *Frequency of Therapeutic Task by Resident and Phase*

	Explore				Apply					Impact				Test		
	1	2	3	4	1	2	3	4	5	1	2	3	4	1	2	Totals
Authority Problems	0	9	20	0	4	19	27	5	8	0	0	0	10	10	0	112
Misleads Others	0	3	0	0	0	0	0	0	0	2	0	0	1	0	0	6
Easily Mislead	0	1	0	0	0	0	0	0	0	0	2	0	0	0	0	3
Aggravates Others	0	7	8	0	0	0	0	6	0	0	0	0	0	1	0	22
Easily Angered	0	3	1	0	19	0	1	0	0	0	0	0	0	0	0	24
Stealing	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
Alcohol/ Drugs	0	11	0	0	0	0	0	0	0	0	5	0	0	0	12	28
Lying	3	3	0	0	0	0	0	0	0	0	4	0	0	0	0	10
Fronting	0	0	0	5	3	0	0	0	0	4	1	0	2	0	0	15
Low Self Image	0	1	0	24	0	9	0	0	0	4	0	0	0	1	0	39
Inconsiderate of Others	26	9	22	5	0	8	0	3	10	4	5	3	2	19	5	121
Inconsiderate of Self	8	22	4	9	0	19	4	2	7	18	4	4	25	3	14	143
Totals	37	69	55	43	26	55	32	16	25	32	23	7	40	34	31	525

Others. In addition, the categories Easily Mislead and Fronting were collapsed with the general category of Inconsiderate of Self. Subsuming these specific categories under the more general terms falls in line with the RTC's prescription for their usage.

As indicated, a trained coder and I followed a guideline that privileged specific vernacular terms over general ones. Tasks that were written in by the coders were analyzed via constant iterative comparison. The following "new" specific therapeutic task vernaculars emerged: Advocating for Self, Social Skill, Education, Thinking Errors, Emotion Regulation, and Family Dynamics. These suggested categories stand as distinct from existing vernaculars and are representative of the terms catalogued during content analytic coding. Each of these suggested categories will be discussed with exemplars in the general discussion in Chapter VI. It is important to note that the new tasks inflate the frequencies of Low Self-Image (e.g., Advocating for Self), Inconsiderate of Others (e.g., Social Skill, Emotion Regulation, Family Dynamics) and Inconsiderate of Self (e.g., Thinking Errors, Education, and in some cases, Emotion Regulation). For now, the discussion of therapeutic tasks will revolve around the existing RTC task vernaculars.

The frequencies reported in Table 9 help to temper assertions made about the relative importance of a given therapeutic task. For example, although the task Easily Angered was retained (see Table 10) for contingency analysis, the frequency table indicates that 19 of the 24 occurrences coded were contributed by the Apply-1 Family.

The Authority Problem, Inconsiderate of Self and Inconsiderate of Others tasks were recorded far more often than any of the other possible categories. Importantly, the table also indicates a fairly equitable distribution across family groups for these three issues. Authority Problems occurred in 9 of the 15 sessions and was coded 112 times.

Table 10 *Collapsed Therapeutic Tasks by Phase*

	Authority Problems	Easily Angered	Alcohol/ Drugs	Low Self Image	Inconsiderate of Others	Inconsiderate of Self	Totals
Explore *	29 (14.2)	4 (2)	11 (5.4)	25 (12.3)	86 (42.2)	49 (24)	204
Apply	63 (40.9)	20 (13)	0 (0)	9 (5.8)	27 (17.5)	35 (22.7)	154
Impact	10 (9.8)	0 (0)	5 (4.9)	4 (3.9)	23 (22.5)	60 (58.8)	102
Test	10 (15.4)	0 (0)	12 (18.5)	1 (1.5)	25 (38.5)	17 (26.2)	65
Totals **	112 (21.3)	24 (4.6)	28 (5.3)	39 (7.4)	161 (30.7)	161 (30.7)	525

*(%) Within Phase
**(%) of Total

Inconsiderate of Self occurred in 13 of the 15 sessions and was coded 121 times, and Inconsiderate of Others occurred in all but one session a total of 143 times.

The salience of authority problems across the stages seems to intuitively fit with both the context and the literature on adolescent development. (Laursen, Coy & Collins, 1998). Authority problems are among the issues most commonly reported prior to admittance to the RTC, and, as demonstrated by the example below, it is an issue that persists throughout the therapeutic intervention.

In this example from a test session, the group has been working on developing a set of expectations for the residents' upcoming graduation and return home. The therapist points out the resident's demeanor.

Therapist: "You okay with that? I can't tell."

Resident: "Um…Yeah."

Therapist: "You're lookin' today like you're guttin' stuff more than you usually do."

Resident: "Well I mean cuz I know like I kind a have to like if I'm gonna be living…"

Therapist: "Yeah, their house their rules?"

Resident: "In their house I'm gonna have to make sacrifices."

The classic "their house, their rules" response was a common indicator of the authority problem issue across the recorded sessions.

The more generic therapeutic task categories, inconsiderate of others and inconsiderate of self, encompassed a wide range of behavior including those task categories that were subsumed based on low frequencies. To some degree, the high frequencies recorded here are reflective of the limited applicability of the more specific

existing vernaculars. This unexpected finding may point to an important contribution the study can make to the RTC. The more specific residents, therapists, and parents can be in defining their therapeutic tasks, the better prepared they are to implement appropriate interventions. Exemplars of these categories are presented below according to their salience in each phase.

Differences in Task Salience

Direct response to Research Question 7 comes from the interpretation of the contingency analysis included in Table 10. The table presents the distribution of retained therapeutic tasks (i.e., Authority Problems, Easily Angered, Alcohol/Drugs, Low Self Image, Inconsiderate of Others, and Inconsiderate of Self) according to the phase of intervention in which they were discussed. Results according to phase and task are described below.

Results by Phase

Participants in the explore phase sessions discussed tasks related to being inconsiderate of others more often than any other. In fact 42% of the tasks discussed in this session fell within this category. As previously stated, the RTC description of residents at this stage of intervention that there is a limited willingness to accept responsibility for behavior and a limited willingness to participate in the therapeutic process. Not surprisingly, the recordings suggest that parents were the typical recipients of the resident's inconsiderate actions. In the example provided below the therapist stops the conversation when the resident "take[s] a shot at dad."

Therapist: "W-w-wait, wait. What the hell was that?'

Mother: "Yeah.

Resident: "He was concerned."

Therapist: " The whole time I'm talking are you just like, I'm talking and you're building this whole thing in your mind of, 'How can I take a shot at dad, I know I know---.' Like the whole time I'm talking that's what you're strategizing?"

Resident: "He was concerned about…"

Therapist: "No, no, no. You're doing it again, you're justifying something. The whole time I'm talking, [resident], you're cookin' up a way to take a shot right?"

Resident: "Yeah. I'm sorry. What do you want to talk about next?"

Therapist: "Is that accurate?"

Resident: "Yeah.

Therapist: "Okay. Then don't."

Resident: "But not the whole time you were talking. It's just…"

Therapist: "I believe that."

Resident: "Like to get back at him and I just said, 'Okay I can do it in a snotty way…'"

Therapist: "Yeah."
Resident: "And use this tone of voice."

The resident's hurtful comments were clearly calculated. It seems, at least in the recordings analyzed here, that in most cases the inconsiderate behavior was deliberately and consciously enacted. That is, these residents were not committing social faux pas based in ignorance. One explanation for this kind of behavior among the residents in the explore phase is that they feel hurt or betrayed by their parents for enrolling them at the RTC. The results reported above indicate that residents frequently expressed sadness in

the Explore phase. Making hurtful remarks to their parents may be the (mal)adaptive mechanism most readily available to the resident to cope with that Sadness.

Forty-one percent of the tasks up for discussion during the Apply phase were related to the resident having difficulty with authority. The example provided above demonstrated that authority problems are persistent, normative to some degree, and often directed at the resident's parents. A second common source of authority in the lives of these residents is the RTC and its staff to be more precise. In the example provided below the resident and therapist discuss the resident's resistance to authority as a hindrance to his achieving his goals.

> Therapist: "Yeah. Well, too, like when they, when they give you a priv slip, take away your free time, and then how you reacted to it. You crumpled it up and threw on the floor, or something to that effect. I can't remember. But, they said, 'Hey, you can get your free time back when you write out your own new priv slip and give it to us.' And how long did that take you to do?"
>
> Resident: "All the way from the third…"
>
> Therapist: "From the third to the twentieth. So, seventeen days? What's behind that?"
>
> Resident: "Um?"
>
> Therapist: "That power struggle or that… because what I worry about is you're motivated, you want to do well, you have these goals. You want to meet with your dad, visit your biological mom's grave, and I see this as being one of those things that can stand in the way of that."
>
> Resident: "I think the thing that is… One, was just saying, you know, 'F… you' to staff. Like, I wanted to hold that position as long as I could."
>
> Therapist: "Why?"
>
> Resident: "Um…"

Therapist: "What's driving that? Because we have to get at what's driving that so we can work on it. To prevent it from happening."

Later in the session, the therapist and the resident discuss the relationship between feeling belittled or embarrassed which was expressed as anger when confronted by staff and engaging these "power struggles." The removal of freedoms or privileges and the institution of firm boundaries are still relatively new for most residents in the Apply phase of intervention. It appears that residents at this stage in the process still struggle to recognize that not all limitations on independence constitute a total denial of independence.

The table reveals that 60% percent of the tasks discussed during the Impact phase recordings were related to the resident being inconsiderate of himself. This finding may offer further evidence of a divide between the "upper" and "lower" phases of intervention. That sadness was expressed more often than any other emotion during this phase seems to fit well with the discussion of problems that are self-imposed. There appears to be an inward turn among the residents who have reached the Impact phase when, as suggested above, it appears that residents begin to take accountability for their actions. And, based on the results presented in Table 10, it appears that residents may also begin to accept that their own behaviors and decisions have brought about their current circumstances. Consider this example.

Therapist: "I appreciate your reading through that…It sounds like… and you correct me if I'm wrong… that part of what you're saying is 'I've come to accept that, yeah, my mom made mistakes, but it's not fair for me to sit here and blame her anymore.'"

Resident: "Yeah. That's like how I feel. That's how I feel like… Um, I've been feeling really bad lately because I've been in treatment and like you guys are spending your money here, which we're going to talk about

> later… Um, because I felt really bad and then like the guilty conscience came in my head and just told me like… just basically like, um, this doesn't feel right. You know? Like I've put my mom and [step-father] through so much and yet they're still there for me. And what have I done to show them like, in the past like… what have I shown them like I've really deserved this. You know?"

The kind of accountability expressed in the example above demonstrates a significant shift in the outlook of the resident when compared with examples from the Explore and Apply phase sessions. This issue will be discussed in more detail in the Chapter VI general discussion.

As in the discussion of emotion expression, the families who participated in the Explore and Test phase sessions mirrored one another with regard to their therapeutic tasks. Thirty-nine percent of the tasks discussed during the test recordings were related to being inconsiderate of others. Whereas these discussions took on a spiteful tone in the Explore phase recordings, there was a more cautionary tone in the Test phase discussions. Here the mother is expressing concerns about her son's eventual return home and about his considering the parents' feelings before making choices.

> Mother: "To me it would pleasing your buddies and trying to look cool to them."
>
> Resident: "But then…"
>
> Mother: "And putting us at the bottom of the heap concerning this. And I'm not saying I'm right. I'm not saying I'm wrong. I think the truth is somewhere in between, but we would hope on something that we do feel so strongly about, that you could seriously think about honoring our feelings just because you hopefully honor us…"
>
> Resident: "M'hm."
>
> Mother: "And respect us and know that we're not just giving rules just to rule you, you know, to be in charge, that we have strong feelings about it."
>
> Resident: "Deep sigh."

This example demonstrates that discussions that fall under the Inconsiderate of Others category were often carried out in an affirmative manner. That is, this conversation seems to be more about being considerate or demonstrating consideration than about responding to an inconsiderate act. Participants in the Test phase seem to be negotiating expectations in anticipation of the residents' re-entry to the family system.

Results by Therapeutic Task

Although not displayed, I calculated the percentage of total occurrences for each of the tasks. The calculations reveal that 64% of all discussion involving low self-image and 53% of all discussion related to being Inconsiderate of Others occurred during the Explore phase sessions. Participants included in the Apply phase sessions were the sources of 56% of all authority problem discussion and 98% of the talk involving the Easily Angered task. Thirty-seven percent of all discussion related to being Inconsiderate of Self occurred during the Impact phase. And, Test phase participants accounted for 43% of the instances where alcohol and/or drugs were discussed. Here again, I tentatively suggest that there seems to be a split between the Explore/Apply family groups and the Impact/Test family groups. Continued research would help to provide evidence to make more definitive claims.

It seems reasonable to suggest in response to Research Question 7, that there are important differences in the kinds of tasks discussed across the phases. Evidence here helps to bolster claims that the discussions recorded during the Explore and Apply phases were the most emotionally volatile. The Explore and Apply phase sessions each produced the majority of occurrences for two separate therapeutic tasks while the Impact and Test

phase sessions were characterized by separate single tasks. In the final section of this chapter, I will address Research Question 8 which asks whether these therapeutic tasks are related in any way to the emotion prototypes.

The Relationship Between Task and Emotion

Table 11 provides the results of a 6 x 6 contingency analysis conducted to respond to Research Question 8. By detailing the distribution of emotion prototypes, given the therapeutic task up for discussion, the contingency table provides a rough estimation of the relationship between these variables.

Results by Emotion Prototype

The table reveals that Love was expressed most often during the discussion of issues related to being Inconsiderate of Others. This result most likely reflects that the coder and I agreed to view the expression "I love you…" and the response "I love you too…" as demonstrations of being Considerate of Others. Note that the tasks Inconsiderate of Others and Inconsiderate of Self were also attended to when participants discussed or demonstrated them in the affirmative (i.e., Considerate of Others or Self). The Joy prototype occurred with equal frequency during discussions focused on being Inconsiderate of Self or Others. Again, this is likely related to discussions of these tasks in the affirmative.

Anger was most closely related to the discussion of authority problems. This finding coincides with the discussion provided above. Struggles for authority and independence bring with them frustrations for both parents and residents. As the exemplars provided above demonstrate, the expression of Anger varied in intensity from

Table 11 *Collapsed Prototypes and Collapsed Tasks*

	Authority Problems	Easily Angered	Alcohol/ Drugs	Low Self Image	Inconsiderate of Others	Inconsiderate of Self	Totals
Love *	5 (8.5)	0 (0)	1 (1.7)	4 (6.8)	34 (57.6)	15 (25.4)	59
Joy	22 (17.1)	6 (4.7)	14 (10.9)	9 (7)	39 (30.2)	39 (30.2)	129
Anger	45 (37.8)	15 (12.6)	3 (2.5)	1 (.8)	31 (26.1)	24 (20.2)	119
Sadness	20 (16.4)	3 (2.5)	2 (1.6)	14 (11.5)	37 (30.3)	46 (37.7)	122
Fear	13 (18.3)	0 (0)	6 (8.5)	11 (15.5)	16 (22.5)	25 (35.2)	71
Other	7 (28.0)	0 (0)	2 (8.0)	0 (0)	4 (16.0)	12 (48.0)	25
Totals **	112 (21.3)	24 (4.6)	28 (5.3)	39 (7.4)	161 (30.7)	156 (30.7)	525

*(%) Within Phase
**(%) of Total

mild frustration with having to live by the "house rules" to anger intense enough to insight confrontation and defiance.

Perhaps not surprisingly, the Sadness prototype occurred most frequently when the discussion focused on the resident being inconsiderate of himself. An explanation and possible silver lining to this finding is that it seems to reflect residents beginning to take accountability for their decisions and behaviors. Taking accountability for one's actions seemed to bring about feelings of guilt, regret, or remorse.

Similar to Sadness, the Fear prototype occurred most frequently when the discussion focus turned to being Inconsiderate of Self. As reported above, the resident was overwhelmingly the source of expressions of Fear. Often these expressions appeared to be related to social anxieties. This finding is likely based on the emergence of the "Advocating for Self" task proposed above. Although I will discuss this "new" task in greater detail during the general discussion, it is helpful here to say that some residents seemed to demonstrate a reluctance to voice their opinions when they were in disagreement with their parents, peers, or therapist. The reluctance was often attributed to anxiety over "saying the wrong thing" or saying something that would result in retribution.

Finally, the grouping of emotions falling under the "Other" category coalesced around the Inconsiderate of Self tasks. Given the inclusion of emotion terms like, suicidal and self-harm, the link between the "Other" category and Inconsiderate of Self appears on its face to be appropriate.

Claims about the relationship between the therapeutic tasks and the emotion prototypes are diluted by the collapsing of half of the RTC vernacular-based tasks. The

coding procedure allowed for the recording of what might prove to be more accurate or salient vernaculars/tasks. This unexpected finding stands as a point for both continued research and contribution to the RTC. Having offered a description of the emotional profile of the family therapy sessions, I turn now to a look at the convergence of meta-emotion philosophy and Meta-Emotion Behavior across the phases of intervention.

CHAPTER V

THE CONVERGENCE OF META-EMOTION PHILOSOPHY AND META-EMOTION BEHAVIOR ACROSS PHASES OF THERAPEUTIC INTERVENTION

At its root, this investigation is a study of communicative behavior. That commitment is exemplified in Research Question 1, which asked, "In what ways do the Gottman's (1997) conceptualizations of Meta-Emotion Philosophies converge with naturally occurring talk (i.e., Meta-Emotion Behavior) during family therapy sessions with adolescent males?" Through focused and iterative readings of the transcribed therapy sessions, I have drawn conclusions about the quality and character of Meta-Emotion Behavior that begin to answer that question. In this chapter, I will address the degree to which communicative behavior matches the emotion philosophies outlined by Gottman and his colleagues, I discuss the apparent structural components of speech turns and sequences representative of the differing philosophies, and I describe, to the extent possible, differences in Meta-Emotion Behavior across phases of intervention and among the various participants. In addressing these topic areas, I will be responding not only to Research Question 1, but also to Research Questions 2, 4, 6 and 6(a). In each section that follows, I will indicate where the discussion addresses these questions. I begin by responding to Research Question 1.

Philosophy in (Inter)action

In short, participants' responses to the discussion and expression of emotion during the family therapy sessions were reflective of the four meta-emotion philosophies described by Gottman (1997). One of the important contributions this investigation stands to make is the level of detail with which these speech turns and sequences can be described. In the following paragraphs, I will provide a table comparing patterns of communicative behaviors discovered in this investigation with each of the meta-emotion philosophy descriptions provided by Gottman (1997). Each table offers a clear starting point for the discussion of these interaction patterns.

Emotion Coaching

Table 12 identifies the behaviors Gottman (1997) suggests are indicative of a coaching meta-emotion philosophy. A brief list of behaviors observed in this investigation are also provided for comparison. The emotion coaching behaviors observed in this investigation fit nicely with the philosophical commitments described by Gottman (1997). In conversation with one another, participants responded to the expression or discussion of emotion by demonstrating that they were aware of and accepted the emotional experience of the other, they demonstrated a willingness to listen to the other, and they provided guidance or feedback about the experience, expression, or regulation of the emotion in some way. These "hallmarks" of emotion coaching were relatively easy to identify and were, to some degree, expected components of coaching behavior.

Table 12 *Comparison of Coaching Philosophy and Behavior*

Coaching Philosophy Description (Gottman, 1997)	Coaching Behavior Description
-Values the child's negative emotions as an opportunity for intimacy -Can tolerate spending time with a sad, angry, or fearful child; does not become impatient with the emotion -Is aware of and values his or her own emotions -Sees the world of negative emotions as an important arena for parenting -Is sensitive to the child's emotional states, even when they are subtle -Is not confused or anxious about the child's emotional expression; knows what needs to be done -Respects the child's emotions -Does not poke fun at or make light of the child's negative feelings -Does not say how the child should feel -Does not feel he or she has to fix every problem for the child -Uses emotional moments as time to; listen to the child, empathize with soothing words and affection, help the child label the emotion he or she is feeling, offer guidance on regulating emotions, set limits and teach acceptable expression of emotions, and teach problem-solving skills	-Provides advice regarding appropriate context for emotional expression -Identifies the emotion being experienced -Provides a space for other to define their experience -Asks other for emotion vocabulary terms -Asks for confirmation of his/her understanding -Advice takes a directive tone -Draws attention to negative consequences with pointed questions -Provide summaries of others previous speech turns –demonstrates listening -Relates past, present and future behavior -Provide limits on appropriate time to engage emotional conversation. -Uses leading questions -Uses probing questions – How do you feel?, Why do you feel that way? -Discerns subtleties of differing emotions -Allows for others to define, modify the interpretation of events. -Focuses conversation, stays in the moment of emotion -Offers advice qualified by "Is that right?", "Does that make sense?" "Correct me if I'm wrong" -Asks others to recognize their own emotion -Models behavior –Implicit-Fish bowl technique -Provide coping techniques-Directive -Probes for clarity regarding emotional experience for others -Describes a continuum of improved coping skill -Tag teams, providing advice after others have demonstrated understanding -Links thinking errors with emotional responses -Asks for emotional reactions -Challenges inconsistent logic -Responds to nonverbal "tone" -Confrontational- actually provokes emotions

Table 12 *continued*

Coaching Philosophy Description (Gottman, 1997)	Coaching Behavior Description
-See Above	-Demonstrates listening with recaps and fillers -Distinguishes between content and relational messages -Advice offered in question form -Discusses primary and secondary emotion responses -Uses a continuum of behavior to describe more appropriate emotional reactions. -Describes connection between behavior and others emotional response -Sets boundaries based on current level of trust -Points out thinking error as an inappropriate coping skill. -Describes perceived barriers to successful coping/expression -Asks other to name the link between emotion and motivation -Uses examples from own experience to relate -Expresses awareness of others emotion -Describes attempts to interact with other when emotional

There were also components in the patterns of coaching behavior that extend our understanding of how coaching works and that were to some degree unexpected. For example, coaching speech turns and sequences were often confrontational even provocative. When coaching, it was common for participants to use probing, leading, and/or pointed questions to gain understanding, demonstrate listening, or offer advice. Advice giving was often qualified in some way such that it became neutral or even submissive, in terms of relational control. Coaching appeared, in many cases, to be offered implicitly rather than in explicit statements or directives. Coaching turns could be linked with particular emotion skills (e.g., using emotion terms or increasing emotional awareness). Finally, it became apparent that coaching behavior directed towards a particular participant was simultaneously modeled for each of the other participants similar to process modeling techniques used by mediators (McCorkle & Reese, 2005). Each of these issues and exemplars will be discussed in more detail below. I begin with a discussion of awareness.

Demonstrating the Awareness Component of Emotion Coaching

As I suggested in Chapter II, Gottman et al. (1996) liken emotion coaching to what Ginot called the "new code of communication." The new code required that parents demonstrate that they understand what it is their children are experiencing before they offer any advice. Of course, demonstrating understanding presupposes that the parents are aware of the emotional experience to begin with. Before moving forward, an important point needs to be made. In this investigation, the ability to demonstrate awareness and acceptance extended to each of the participants including the adolescent

residents, thus moving away from the traditional top-down (i.e., parent to child) view of emotion coaching.

Awareness, of course, refers to the ability to recognize that another is experiencing an emotion. In the following example, we see a therapist responding to a conversation between the resident and his father. The sequence provides insight into the way awareness was demonstrated, discussed, and coached across the recorded sessions.

Father: "I was kind of wanting to bring up the next subject, [Resident], with this, is on Sunday night you said, 'Hey, where's [Brother]?' 'He's right here.' And you said, 'Hey, [Brother], how's Huntington?" And correct me if I'm wrong, but it really seemed like a rub. You were trying to rub him a little bit on that."

Resident: "On what?"

Father: "On going to Huntington. The first thing you asked, I mean, 'How was…"

Resident: "What also am I supposed to ask him about, dad? Like I've been away from home for five months…"

Therapist: "Wait, wait, wait, slow down. What? I mean I guess I'd, I'd like to back up to your dad's question. Were you trying to kind of take a shot a little bit?"

Resident: "No."

Therapist: "Okay."

Resident: "The only thing I know about the kid in the past five months is that he joined swimming and he goes to Huntington Learning Center."

Therapist: "Yeah, don't get defensive. Why are you getting defensive?"

Resident: "Because it kind of makes me mad. Like I'm not kind of trying to start a fight with my brother over a ten-minute phone call."

Therapist: "Okay. Again, again, it sounded to your dad like you were kind of rubbing his nose in, you know, how's the short bus? Is maybe how

> your dad wondered if that's what it meant. It's a question to ask. Is, is, did, [Brother] take it that way? Did he kind of come away with a…"

Stepmother: "We didn't discuss it with him."

> Therapist: "… I don't know, I can see how he would experience it that way. Like, even if that wasn't your intent. Maybe the trick would be to be kind of sensitive and, you know, next time phrase the question as, you know, 'Hey how's school?' You know, that, um, maybe mentioning the name of it, I can see how he could have experienced it, or how your dad might wonder, was that kind of a cheap shot?"

> Resident: "Well, yeah, I mean I understand and I can rephrase the question and stuff. The only thing I about know about the kid now in the past five months are what he's doing lately is Huntington Learning Center

This sequence begins with the father raising a "sore subject" in the household. Subsequent speech turns indicate that the father's decision to raise the issue stems from concern that the resident's brother may be or become embarrassed by attention to his enrollment at a school designed to help students who struggle academically. Raising the issue indicates an awareness of the potentially emotional response to the resident's comments and simultaneously suggests to the resident that he should be aware of that potential as well. The turn implicitly places a boundary on the way "school" should be talked about with the resident's brother.

The therapist's turn that begins with "Wait, wait, wait…" demonstrates that he is clearly aware that the resident is becoming frustrated with the conversation. The therapist refocuses the conversation on the issue at hand, provides the resident with an opportunity to answer the father's original question, and accepts the resident's answer with a simple "Okay." In the next turn, the therapist names the emotional response he is sensing from the resident. It is important to note the midsentence switch that the therapist performs

here. He begins by *telling* the resident not to be "defensive." He finishes the sentence by *asking* the resident why he is being defensive. Although the switch may seem subtle, it carries an important relational message. It provides the resident with the space and agency to define the situation for himself. These are critical subtleties that reoccur across sequences indicative of coaching, and I will discuss them further below. For now, I return to the discussion of awareness.

Given the opportunity to respond, the resident indicates he is "mad." Again, the therapist accepts the response with a simple, "okay" and refocuses the conversation on the potential emotional reaction of the resident's brother. The therapist's final turn is the most important in this sequence. Note the turn begins with "I don't know…" this qualification allows for what comes after to be seen as *an* interpretation rather than *the* interpretation of the event under discussion. This kind of qualification preceding the feedback/advice giving invites the resident to engage, as opposed to simply receive or take the message. The advice that was offered points to the importance of recognizing that even if unintentional, the way we interact with others can have emotion eliciting outcomes.

The resident is cued to be more aware of the way he interacts with his brother with regard to school in particular, but the lesson extends to awareness more broadly. Katz and Hunter (2007) discussed the possibility of decreased awareness among parents (mothers were included in their study) once their children reached adolescence based on the tendency of adolescent children to turn to their peers for support rather then to their parents. If the issue of awareness were linked solely to explicit expressions of emotion,

that might be true. It seems more likely, however, that the issue of awareness extends to a more intuitive or empathic sense of emotion. In the exemplar above, the resident is asked to anticipate the emotional ramifications of his conversational choices not simply be aware of and respond to an expressed emotion.

It is also important to note the use of questions in this sequence to increase, raise, and coach awareness. The therapist inquires about the actual response displayed by the resident's brother. The question helps the therapist understand the event more clearly, and, at the same time, begins to illuminate the situation for the resident. The increased awareness brought about by the discussion can, in turn, help the resident in future interactions. To aid in that process, the therapist offers suggestions about how the resident might change the tone of future discussions about school. I turn now to the issue of acceptance.

Demonstrating the Acceptance Component of Emotion Coaching

A second important dimension to coaching philosophy and behavior is that of acceptance of an emotional experience. Examples of acceptance from the therapy sessions tended to fall within two categories of response. First were instances of simple, often explicit acceptance. The second and more often implicit form of acceptance fell under the realm of demonstrating understanding or attempts to understand. Understanding and acceptance should be considered similar but separate concepts. Acceptance should be taken to mean that one is viewed as capable of and entitled to

experience any emotion.[18] It seems helpful and representative of the kinds of responses tracked among these participants to say that understanding, or attempts to understand, could be viewed as a bridge between awareness and acceptance. Attempts at understanding (e.g., asking follow-up and probing questions) demonstrate some level of awareness, of empathic concern and therefore by default some level of acceptance. That is, if one was not aware of and/or did not accept the other's emotional experience he or she would likely not attempt to understand it. I can also say that demonstrations of understanding (e.g., use of analogy or sharing similar past experiences) seemed to provide participants with a sense of commonality between themselves and the person responding to their emotion. Such a connection brings with it an implied sense of acceptance because the storyteller is detailing a time when he or she has felt or experienced the same or similar emotions.

Simple acceptance of emotion during the family therapy sessions was typically offered explicitly. The mother in the example below provides simple and explicit acceptance of her son's emotions.

> Mother: "Well, I just want to let you know [resident], that, you know, how you feel, reiterating what [therapist] said, it's not wrong, you know, again it's what you do with it, but I think it's important to be aware and allow yourself to recognize how you feel and trust that, you know, we're not going to discount how you feel, because they're your feelings."
>
> Resident: "M'hm."

Other instances of simple acceptance were less explicit but no less accepting; consider the therapist's responses in the following example.

[18] This level of acceptance refers to the experience rather than the expression of emotion. One may accept the experience and reject the expression of a given emotion.

Therapist: "Oh, wait. What was that?"

Resident: "I don't like him touching me."

Mother: "He didn't."

Resident: "Well, he was like going to."

Therapist: "M'hm."

Mother: "This is an interesting thing to explore."

Resident: "I don't like that."

Therapist: "M'hm."

Resident: "I just really don't like that."

Therapist: "Right. So is there a way that you could express that more appropriately? Again, I think…good, better, best. I mean, you know, so, so I appreciate the fact that you didn't like slap his forehead and say, 'Don't touch me.' That would have been the worse, but, uh, and, and kind of elbow of his hand away is not very good. And a little better would be to shrink back and say, 'Don't touch me! Don't touch me!' And then a little better than that would be 'Dad, you know what? Like, I'm still kind of…that's on my list of things to work on still and I'm still a little sensitive about that.' And, and better would be to allow it to grind your teeth and then, and maybe the best would be to find a way to appreciate the gesture of affection. Um…"

Here the therapist catches the resident recoiling from his father's attempt to touch him during a session conducted while the parents were visiting. The acceptance is very subtle but straightforward. Short filler responses of "M'hm" indicate to the resident that the therapist is listening and carry an open as opposed to closed or rejecting tone. This is followed by an advice giving statement that is prefaced with the word "Right" indicating that the therapist has heard, understands, and accepts that the resident is angry with his father. Finally, the therapist asks the resident to consider progressively more appropriate

ways to demonstrate his dislike. The resident is not admonished for disliking his father or more accurately, not liking to be touched by his father, rather the focus of the comments are on setting appropriate limits on the expression of his dislike or anger. Similar to the more explicit example of simple acceptance, the form of this response suggests to the resident that his feelings are his to decide but the expression and regulation of those feelings should fall within certain boundaries.

Demonstrations of understanding and making attempts to understand another's emotion were the second common form of acceptance across the therapy sessions. Demonstrations of understanding were often offered as stories from the past or an analogy that indicated a similar emotional experience. In the segments provided below the therapist first offers an analogy to help the resident understand his parent's position and emotions surrounding the resident's desire to get a lip ring once he graduates from the RTC.

> Therapist: "Well, let's say hypothetically I called my wife today and I said hey me, [male D], and [male E] are gonna go to Hooters for lunch and, and uh, you know we're gonna kind a make that a standing thing that on Friday afternoons, just as a way to unwind from work a little bit, we're, we're gonna go have lunch at Hooters. Um, and Hooter, I mean Hooters isn't illegal, it's not even, you know, nobody's stripping at Hooters or anything. Would she have an emotional reaction to that? You don't know my wife."
>
> Resident: "Yeah, I mean I can imagine she would."
>
> Therapist: "She probably would. Yeah, she would, she would, uh, and she would express, you know [therapist] if it's all the same to you could you maybe go to Carl's Jr. or something instead of Hooters? Is she gonna leave me if I go to Hooters? Well, probably not, I mean it's just, you know, I'm going to eat at this place. It's not, you know, again it's not a strip club, it's not that far out there, but I, she would experience that as fairly disrespectful of her. Um she, she would experience, it would,

> it would change the way she looked at me a little bit. She is not going to probably make me sleep on the couch, or, and, and she's not going to, to punish me per say, but, but, yeah it would probably change some of the dynamics in our relationship. And that's not her, again, that's not her punishing me and saying 'No, no, you're going against my will and you're gonna pay.' But it would have an effect probably. Um…"

In the description above, I suggested understanding could be viewed as a bridge between awareness and acceptance. It seems clear that this analogy is aimed at both raising the resident's awareness and accepting the parent's emotional response. Later in the same session, it becomes clear that the mother struggles to see her son's point of view and/or emotional response to her stance on the lip ring. The therapist returns to the analogy to raise the mother's awareness and accept the resident's emotional response.

> Mother: "Of course, you know, you're knock dead, knock dead, drop dead gorgeous as it is. Why mess with perfection? I mean you have girls who won't leave you alone because of the way you look now, so why change your looks when it works for you? And, you know, and you can change your clothing and you can, you know, if you want to appear something similar to that, you could change you clothing and then when you're tired of it that night you can take it off, so, I guess that's our feelings, and we've made it clear, but it ultimately is up to you. But I just hope you will consider our feelings."
>
> Therapist: "Now I'm curious, if, so if I talk to my wife about going to Hooters and she expressed her feelings and, and there's some chance that I might go away with some resentment and says 'man, ball and chain, won't let me do anything with the boys,' and and…"
>
> Father: (chuckles)
>
> Therapist: "And is that some of what, I mean there's risk both ways, I mean, obviously if I were doing it, there's that risk that she would feel sort of betrayed and 'geez, [therapist] must not be satisfied in our marriage if he wants to go stare at these waitresses and whatever. But there is some risk I guess that I could come away feeling like 'man, she just ties me down, won't let me' you know, 'thinks I'm a little kid or doesn't trust me enough to…' Are you struggling with any of that?"

Resident: "Yeah."

Therapist: "Kay. Tell us about it."

Acceptance by understanding is important at the relational level of the message. Providing evidence that you understand the emotion that your interaction partner is experiencing grants you the opportunity to offer up advice or feedback from an "informed" or "qualified" position. That is, a demonstration of understanding may suggest an ability to provide useful advice. For me, this is/was the great power in Ginot's new code of communication. Qualified advice giving was an important pattern among the instances of coaching across each of the therapy sessions. I will talk about that more below. For now, I turn to the second form of acceptance by understanding: attempting to understand.

In some cases, participants were not able to offer an analogy or past experience because they did not understand the other's emotional experience. In these cases, acceptance was granted by making attempts to understand via probing and/or follow-up questions. In this example, both the mother and father are asking probing questions to understand the resident's description of his depression. The therapist asks a follow-up question that demonstrates his understanding and helps the parents to understand.

Resident: "Cuz I got into the, 'I feel crappy, but I feel good at the same time' mood."

Mother: "It felt good to feel crappy?"

Resident: "Yeah. Like the kind of depression that I create, like I made up a scale, like there's, uh, my depression is this big and half of it is real depression, like what's actually wrong with me and the other half would be the stuff that I make make me depressed. Like my created depression. Because I think a lot of my problem is that I, a lot of times

> want to be depressed because I've become accustomed to it and I've, yeah, I've found benefits in it and stuff."

Mother: "What are the benefits?"

Resident: "I don't have to do anything."

Father: "Which results in what?"

Resident: "More depression."

Father: "Okay. So, that's a benefit?"

Resident: "It's a short term benefit that turns into a long term bad."

Father: "I mean a short term benefit is just that you're not doing anything?"

Resident: "I don't have to do anything."

Father: "I guess I don't understand. How's that a benefit?"

Resident: "I don't want to do anything. I'd rather just lay down and think about stuff."

Therapist: "It's a benefit because how far in the future are you looking?"

Resident: "Not very far. I'm thinking about right now."

> Therapist: "Right. So, and, and maybe, [father], that's why you're like, 'How's that a benefit?' because maybe the way you're looking at it is, 'Well, how's that gonna impact you in an hour or in a day, in a week, in a month?' Whereas [resident] maybe not even thinking, 'How's this gonna impact me in even a minute?'"

Father: "M'hm."

Probing questions can also offer a sense of anticipated acceptance in advance of an emotion actually being expressed. Here a resident asks his parents how they feel about his therapeutic progress.

Resident: "Yeah. Yeah, I would like to know your guys' response. Mom?"

Mother: "Son, please refresh my memory. (chuckles) What was your question, Honey?"

Resident: "Um. Just like, like how do you guys feel like with me being in treatment, and really like when I first started off, like how was that like really impacting you guys? And like how does like… like, how does my progress like feel to you guys. Like, does it feel real, does it feel like it's like really there? Or just like fake, you know?"

Attempts at understanding via probing or follow-up questions share a common thread of openness to the expression of emotion from the perspective of the person who is having the experience. That openness provides a sense of acceptance characteristic of coaching philosophy and behavior.

An interesting phenomenon related to the issue of acceptance was exhibited by residents who were unwilling or unable to accept their own emotion. Neither parents nor therapists exhibited this behavior in any of the sessions. The problem is illustrated in two separate but related exchanges from the same session. Here the therapist uses questions to tease out the resident's experience and to offer a space for the resident to express himself.

Therapist: "What are you feeling right now, [Resident]?"

Resident: "I feel" (exhalation) "I feel, uh, really angry right now, but I'm not supposed to be angry."

Therapist: "Who says you're not supposed to be angry?"

Resident: "Because I'm in treatment. I mean, come on man, I'm, I'm supposed to be doing work on myself, I'm not supposed to be getting angry at my parents. Of all things, they've done the very best they could for me sending me here and getting me all this help. And then I go off and I… get pissed at them because of something that happened freakin' ten months ago or something. And…" (exhalation) "And I… I haven't felt this way…" (exhalation) "I haven't felt this way since that therapy session with Dr. [name] or…" (exhalation)

Therapist: "So, you're angry that you're feeling this way?"

Resident: "It's stupid. I'm angry that I'm feeling angry. I'm frustrated with myself because I shouldn't… shouldn't… I shouldn't be feeling that way."

Therapist: "Who says you shouldn't?"

Resident: "I'll get… I just…" (exhalation) "Because this is the exact behavior that my mom's always talking about when I feel this angry."

Therapist: "Ah huh."

Resident: exhalation

Therapist: "Is there a better way to help you work through than to maybe actually experience it."

The therapists final turn here is important because part of acceptance, according to the Gottman (1997) descriptions, is an ability and willingness to remain "in the moment" of the experience. Here the therapist suggests that ultimately, the resident will learn to regulate his anger by being willing to be angry. The exchange continued and the resident's emotions (i.e., a mixture of anger and sadness) remained escalated. Below the therapist attempts again to suggest to the resident that his experience and his expressions are perfectly acceptable, noting his use of coping skills.

Therapist: "Okay. Can I point something out? I've seen you get worked up a number of times. But you are practicing the deep breathing. You are keeping yourself in control, you're not breaking things in my office. At this point, I'm not worried about you lashing out against me. I'm not dialing on my cell phone for other people to come in the office because I'm worried that you're going to be a threat to yourself or others because you are practicing coping skills to remain in control. And even these emotions that are uncomfortable and very overwhelming, you are showing that you have the ability to manage these, [Resident]. That's huge. I'm not worried about you putting a hole in one of my walls. As uncomfortable and awful as it is to feel this way, you are showing more control that you may have the thought

> that you want to stab yourself in the chest again or something like that, but you are working through it. Do you recognize that?"
>
> Resident: "Yes."
>
> Therapist: "How does that feel?"
>
> Resident: "Um, thank you for your kind words and I know they're honest. I don't feel like I can, I'm really in the place to think too positively of myself right now. Positively."
>
> Therapist: "Okay."

Despite the therapist's efforts, the resident continues to find his own emotional experience as unacceptable. Notice that the therapist accepts this response with an "Okay." Importantly, acceptance is an issue that needs to be considered from the perspective of both the person experiencing the emotion and those who are available to respond. Emotion Regulation Theory (ERT) suggests that if this resident is met with continued accepting responses and continued coaching with regard to coping skills for his anger, he will become more open to accepting the anger he feels towards himself and his parents. Presently the resident seems to hold a disapproving meta-emotion philosophy (i.e., he is angry that he is angry). To understand if the process change over time predicted by ERT would apply to residents' increased ability to accept negative emotions, longitudinal work would need to be carried out.

The acceptance component of coaching, as has been described here, is dynamic and interactive. Demonstrating acceptance in interaction seems to be linked very closely with offering supportive comments that affirm the experience of emotion, asking questions, and/or offering similar experiences or analogies. Acceptance can be offered explicitly or implicitly. And, acceptance/understanding provides the person responding to

emotion with a platform from which to offer advice, to coach. I turn now to a discussion of listening.

Demonstrating the Listening Component of Emotion Coaching

Listening is an important interpersonal skill that is used daily in everyday interaction, but it is also a skill used and modeled by professionals such as mediators (Kimsey, Fuller, & McKinney, 1993) and counselors (Hutchby, 2005) to help surface important issues and emotions when working with troubled or struggling clients. This too fits with descriptions of an emotion coaching philosophy (Gottman et al., 1996). Attention to speech turns and sequences indicative of coaching were infused with demonstrations of active listening. Participants in this study offered recaps, reframes and fillers to demonstrate that they were listening to others during the therapy sessions. Listening is a skill that touches upon each of the other components of coaching. To be aware of others' emotions, to understand and/or accept others' emotions, and to be prepared to offer advice, one must be actively engaged with (i.e., listening to) their interaction partners.

Evidence of vocal filler words used to indicate listening was provided in an example above. Words like "uh'huh," "m'hm," "yeah," "yup," and "okay" were used throughout the conversations. For the majority of the participants, these therapy sessions were conducted remotely. That is, parents were on separate phones, usually in their homes, while the therapist and resident sat together in the therapist's office. These vocal fillers offered important feedback given that other nonverbal behaviors were not available. It seems likely, however, that these same kinds of fillers would be important

even if the participants were face to face. In fact, they were used just as frequently in the two sessions conducted on campus and in person. Often, vocal fillers were used by a participant in the speech turns that preceded his or her use of a recap. That is the case in the example below. Here a resident is discussing his outlook on having an enjoyable life and being able to use marijuana (in moderation) when he leaves the RTC. In the previous turns the resident's stepmother reminded him of the trouble his drug use caused in the past and the difficulties that she had experienced as a drug abuser. The resident acknowledges those issues but persists.

Resident: "I mean, it does take that hold of you…"

Therapist: "M'hm."

Resident: "I mean but… there is that point in your life where none of your friends do it, nobody around you does it, and it just loses its appeal."

Therapist: "M'hm."

Resident: "I mean alcohol did that for me. Drank a little bit, just never really liked it, and then all my friends just stopped drinking and I was just like all right I'll be done with that."

Therapist: "So, I guess, let me, because I think I'm hearing what your saying… it sounds like at least you're saying, 'Okay, I am, I know that if I use my life is going to go to shit, but, but I'm kind of going to go with that and I accept, you know, that it'll be fun sometimes when I'm high and it'll be pretty shitty a lot of times because a lot of bad things are going to happen, but I'll kind of go with that and once my friends kind of grow out of it, you know, then maybe I will too."

Resident: "Yeah. Kind of. I mean, I don't plan on going to the extent I was before like…"

The therapist is tracking the conversation as indicated by the use of vocal fillers. He pauses the conversation to check in with the resident to be sure he has a grasp on the

resident's position. An important point to make here is that the recap is offered up with qualifications "I think I'm hearing what you're saying" and "it sounds like." The use of these phrases helps to keep the speech turn open to corrections or modifications from the resident. This is important because if the resident accepts the recap or offers only a minor modification, then the recap becomes a demonstration of understanding. As discussed above, understanding is a platform from which advice giving is and can be supported.

In addition to vocal fillers and recaps, participants also demonstrated listening by reframing. Participants, most often the therapist, would recast the situation presented by another not to change the issue or emotion, but rather to change the orientation or approach to the issue or emotion. In the example provided below, the resident has been confronted about his preoccupation with an anticipated date for going home and going to college. The distraction has become detrimental to his progress at the RTC and to his relationship with his mother.

Therapist: "And what if that's unknown at this point?"

Resident: "I have anxiety."

Therapist: "Great! So, it's a great opportunity for you to work on dealing with that anxiety. You're going to need plenty of practice on working on dealing with your anxiety."

Resident: "There can be no greater anxiety than college or getting a job, but other than that, I don't think it gets worse."

Therapist: "Well, good. So it's a good challenge. It's not just this lighthearted, easy challenge."

In these and previous speech turns the resident suggests that the anxiety he experiences from not knowing when he will be going home distracts him to the point that

he is unable to focus on making therapeutic progress. For the resident, anxiety is a barrier. The therapist, on the other hand, casts the anxiety the resident is experiencing as an opportunity to practice. Similar to the PPG groups described in Chapter II, residents are encouraged to see their enrollment at the RTC as an opportunity to deal with "problems," to problem solve in a relatively safe environment. Importantly, the therapist does not suggest that the anxiety is unwarranted nor does he suggest that going home, going to college, or getting a job are unworthy goals. Rather the shift in orientation is in how to "work on"/ "deal with"/regulate the anxiety. In other words, the therapist indicates to the resident that he hears his concerns.

Although it seems like a very basic component of coaching, and interaction for that matter, listening is a skill that requires effort and attention. Participants in this investigation were able to use vocal fillers, recaps, and reframes to demonstrate to their attentiveness to one another. More often than not, participants who coached were willing listeners first. That willingness provided them an opportunity to demonstrate their awareness and acceptance which, in turn, made them informed or qualified advice givers. I turn now to the final major component of emotion coaching behavior: advice giving.

Demonstrating the Advice Giving Component of Emotion Coaching

Advice giving is really the quintessential component of an emotion coaching philosophy or behavior. This component sets emotion coaching apart from simply being empathic, sympathetic, or supportive. This is not to say that these are not appropriate or useful ways of being or of interacting with others. Indeed, in the process of coaching, a person may utilize one or all of these standpoints. What makes coaching different is that a

lesson is involved, a set of boundaries put into place, a new method of coping with or regulating emotion discussed, or a range of other guidelines offered up for future emotion-laden interactions. Throughout this chapter, I have referred to the participants in the examples as qualified or informed advice givers. They earn this title by demonstrating their awareness and acceptance, often because they have been good listeners.

Before I move forward with this discussion, I think it is important to unpack the terms "informed" and "qualified." By "informed," I am referring to the development and demonstration of understanding the emotional experience that a person is presented with. As was discussed above, this is often accounted for by asking probing or follow-up questions or, when the person is familiar with the emotion, sharing an analogy or past experience. My usage of the term "qualified" is a bit more complex. I am, on the one hand, invoking its reference to having the necessary information or skill to accomplish the task at hand (i.e., offer advice regarding emotion regulation). On the other hand, I am invoking its reference to a limited or modified expression or statement. As such, I will be using the term "qualified advice" hereafter to refer to advice given in such a way that it has either been subjected to confirmation from the person expressing the emotion under discussion or is offered by an "informed" advice giver. In fact, based on the evidence from this investigation, I can argue that advice offered in an "unqualified" fashion falls under the category of dismissive behavior.

To help clarify my points regarding qualified advice, I have provided examples below. This first excerpt demonstrates advice followed by the qualifier, "Make sense?"

The short phrase leaves an opening for the resident to confirm or modify the feedback he receives from his mother.

> Mother: "And there are even unintended consequences, you know, that I see happening with that, and that is, okay, so you get, you get put on YZ[19] so you miss school, and then you get behind, and then you get overwhelmed because you're behind, and then you get more anxiety. And so it's not just the simple priv thing, it permeates into the rest of, of life. Make sense?"
>
> Resident: "I can definitely see that."

Qualifiers were also used at the beginning of an advice-giving speech turn. In this example, a mother and son are negotiating topics of conversation that have resulted in hurt and anger in the past.

> Mother: "I think, [resident],… from my perspective that doesn't preclude us talking about what you want to do in the future, you know. I think if that's something you want to talk about… you know you mentioned the army and stuff… I mean, I think that's fine as long as we don't end up going with… 'Well, exactly when and whether I am going to be able to do that…' And then it evolves into… 'Well, when am I going to get out of here?' But in terms of talking about your future plans, I don't think that's off the table. I'd be interested to hear, you know, what you would like to do and kind of how you came around to that and what you've learned in your research about it."
>
> Resident: "Mm. Okay. That is something we can do… fill you in on that. I'm just still trying to debate what I want to do when I get out of high school, I guess.

Claiming this turn as her "perspective" makes it just that: one side of the issue and open to input and/or modification from the resident. These examples demonstrate a constitutive approach to interaction. Whether the participants are consciously or strategically enacting

[19] YZ refers to Yellow Zone, a precautionary restriction placed on residents who violate RTC safety codes. While "on YZ" residents are restricted to the dormitory area of the campus, disallowed to go to the school and within staff sight at all times.

them is difficult to say. What is important is that these speech turns invite participation in the social construction of guidelines for future interaction rather than act as definitive statements.

Another apparent trend in the form of advice-giving speech turns includes offering continua of progress that recognize accomplishment and at the same time help to project the next logical steps toward progress for future interactions. Continua of progress were used by therapists in the examples included in the above discussions of awareness and acceptance. Here we see a father attempting the technique with his son.

> Father: "In the past, [resident], in these situations what you often have done is just badgered, badgered, badgered till you got what you wanted, or you got, you know, or where things broke down completely. I must say, when we were together, you didn't do any of that and I think that's good. But, you were clearly unhappy when you couldn't get an answer to the question, or you didn't like the answer you were getting, that we just didn't know and it was up to you. And that, you know, wasn't satisfying or not what you were looking for and so you were unhappy and walked away at one point. But that was a big improvement over, you know, what you would have done before, which would have been to badger and things would have escalated from there, and the answer wouldn't have changed, but it wouldn't stop you from continuing. So, anyway, I want to add that, for what it's worth."

There were also direct attempts to engage residents in describing their own progress over time.

> Therapist: "So, uh, [Resident], what's the change that's happened for you? What would you say, from when you first got here where it was like 'Mom's fault' and, you know, 'She was the one to blame,' because I remember having that discussion with you, um, to now, what, did the, how did the light bulb go on? I mean, when did it, I mean can you quantify or describe that?"
>
> Resident: "Um, probably just like getting more self-confidence and trying to do better if I messed up. Um, I wasn't doing what I said I would do, which was one of the things that got to me the most is, is ---- and then

I get pissed at myself when I don't get it done because, you know. And like I think that was like, that's what leading me to be like a little like more okay with myself like each and every day and like I'm being more calm and more mature, you know, I guess you could say."

Therapist: "As you gain confidence, um, you had more ability to accept responsibility."

Resident: "Yeah."

Mother: "Oh, good."

Father: "That is good."

Offering and participating in the description of continued progress over time is a way to demonstrate awareness and acceptance of the effort involved, the shortcomings that remain, and the agenda for future progress. The process of (re)learning emotion regulation skills is a difficult one. It seems likely that for these families frequent reminders of how far they have come are important morale boosters and inducements for persisting with the process. A therapist articulates this point well in this exchange.

Therapist: "M'hm. M'hm. Okay, I think, I think it's probably useful to think of most of this stuff on a continuum. And so, uh, kind a…you've heard me talk about this a lot in group with one of the guys on your team who gets angry and blows up a lot. That, that we'll talk about that there's it's all about incremental progress. You know, he's not gonna get over the anger today…"

Resident: "So like…"

Therapist: "Sso we'll talk about what progress he is making and what he is working toward."

Resident: "Yep."

Therapist: "Never, never really satisfied. Like knowledge of the progress that we're making, but not be satisfied with that. I think that's probably a useful approach to take with you and your parents, is, is, let's not get satisfied and say, 'This is good enough' at any point, but let's also

> acknowledge, 'Okay, what you're doing today is a heck of a lot better than what I would have seen a month ago.'"

Resident: "That's fine."

Questions are also an important part of qualified advice giving. Probing and follow-up questions were noted to be of importance in the demonstration of awareness and acceptance. Here too probing, follow-up, and leading questions were used to offer advice and help participants reach their own conclusions about their emotional experience.

Therapist: "What emotions are you feeling right now, [Resident]?"

Resident: "Um, right now I'm, emotion-wise, I'm feeling a lot of… uh… down, like loathing kind of. I feel the loathing that I experienced, um, when I was… that day. I remember… because it was one of the probably, it was one of the most a, depressed days of my life, I guess. I… That night I considered doing many times what I did six months ago."

Therapist: "What are you referring to?"

Resident: "When I stabbed myself."

Therapist: "Okay."

Resident: "I guess… sorry guys…"

Therapist: "It's okay, work through it. Push it out, don't keep it… don't hold it in."

Resident: "Um, now if I, if I let it out, it would be like I'd start yelling or something, I don't know."

Therapist: "Can you let it out in a different way?"
Resident: Begins to cry

In this example, the therapist probes for an emotion term, asks the resident to "work through it" rather than deny the emotion and allows the resident to select an appropriate

coping mechanism rather than telling him what to do. In the introduction of this document, I included a quote from Ginot that refers to the difficulty parents experience in letting their adolescent children become independent. The use of leading questions as a part of advice giving might be considered a small but important part of that process. The real art to advice giving may be in getting others to a point where they can, in effect, advise themselves.

Beyond the Basics of Emotion Coaching

Having described the basic components of emotion coaching behavior (i.e., awareness, acceptance, listening, and advice giving) I can say, in partial answer to research question 1, that emotion coaching behavior aligns very well with the components of an emotion coaching philosophy. Importantly, however, we can move beyond these basic components to a more detailed understanding of emotion coaching in interaction. As I suggested above, there were some aspects of coaching behavior uncovered in this investigation that expand on the character of coaching beyond what might have been expected. Some of these issues have already been raised. The importance of questions to demonstrating each of the basic components of coaching is one issue, and, the importance of offering "qualified" advice is another. Still, I have not yet discussed how coaching can often be confrontational, that coaching is often implicitly modeled, and that coaching can be linked with attention to particular skills of emotional competence.

The Confrontational Coach

Whereas a cursory reading of the emotion coaching literature might suggest a soft, even saccharin, approach to handling the expression of emotion from a relational partner, this would be a mistaken interpretation. Across the spectrum of therapy sessions investigated here, instances of coaching could be characterized as confrontational, even provocative. This finding should not be taken as wholly unexpected, however, given the overarching commitments of the RTC to a positive peer culture (PPC) approach to milieu therapy (Vorath & Brendtro, 1985). As indicated in Chapter II, a PPC works in a climate geared toward change rather than security. The RTC fosters an environment where maladaptive behaviors (e.g., dysregulated emotions) are challenged. The reframe example provided during the discussion of the listening component of emotion coaching falls within this category. Here in an example from that same session is an instance when the therapist is actually provoking the resident.

> Therapist: "Does this make it easier for you, Mom, if I continue to ask you about can I come home? Can I come home?"
>
> Resident: "No."
>
> Therapist: "Why not?"
>
> Resident: "Are you saying I'm selfish? I mean, I don't care about my mother. Is that what you want me to say? Because it's not true."
>
> Therapist: "Are you upset?"
>
> Resident: "Yeah. I'm offended."
>
> Therapist: "You're offended? You're offended by what?"
>
> Resident: "Because you're hinting about the fact that I don't care about my mother."

Therapist: "I'm not hinting at that fact. I'm letting you know that your overt behavior shows you don't care about your mother. What did your behavior in New Jersey show? You come back here and you talk about how worried you are about your mom and wanting to protect her and take care of her. What did your behavior in New Jersey show that demonstrated that's how you really feel?"

Resident: "It didn't."

Therapist: "Now that you're back here in Utah and you can actually show her that you do care, that you are worried about her… what you're focused on is 'Are you going to let me come home, yes or no, Mom?' Your mom sent me a couple of emails this week. Both emails had a similar theme. 'I don't have a clue what's happening with my son. I don't have a clue why he's behaving this way.'"

Resident: "Because I talk to her twice a week."

Therapist: "And when you do talk to her it's not about helping her understand why you behave this way or what's going on with you, it's about 'Mom, let me come home to New Jersey.'

… No response?"

Resident: "Every response I say is, is a, proved wrong, and proof that my thinking is wrong, and proof that what I was doing was wrong, so I'm just… I have no response."

Therapist: "So, do you want to do something different about that thinking?"

Resident: "Yeah."

Therapist: "Or what you're doing? Great. Then take the opportunity right now. Talk to your mom. Ask her some questions."

Resident: "Mom, how has this past month(ish) been for you?"

This is not a comforting or overly supportive exchange between the therapist and resident. It is a coaching response, nonetheless. The therapist is direct about the disconnect between what the resident claims he feels about his mother and what his

actual behavior suggests. The therapist is not, however, denigrating or dismissive of the emotion. The therapist gives the resident an opportunity to name his emotion, asks if the resident wants to change his behavior, and gives the resident the opportunity and advice about how to do so. Exchanges like these were common enough across the therapy sessions to suggest that a confrontational or perhaps more broadly, a problem-solving orientation to discussing emotion is indicative of a coaching response in this context. This assumes, however, that each of the basic components of coaching is also present.

The Implicit Modeling of Emotion Coaching Behavior

One of the benefits of family therapy is the introduction of a new variable to the system. The therapist has a unique position that grants perspective on the patterns of interaction that are difficult to recognize for the members of the family. Often it became apparent that even taken for granted process skills like turn-taking needed to be fostered among the participants. In some cases, therapists modeled or directed the turn-taking process so that each person had an opportunity to speak and to be heard. In the following example, the resident had just concluded reading from a list of behaviors that he had lied to his parents about. The therapist offers his observations before asking the parents to respond.

> Therapist: "Okay, so I didn't hear your parents like start screaming at the top of their lungs. I didn't hear them extremely shocked by anything you said. Maybe some of it was some new information? But it sounds like at least, and [Father] and [Mother] please correct me if I'm wrong, that your parents probably had a pretty good idea about what was going on. You know, maybe a little bit shocked about the amount of drugs you were using or, you know, the mixtures you were using, but for the most part it sounds like, 'Yeah, this is kind of what we assumed.' Is that the case [Father] and [Mother]?"

Father: "You know, that's... Yeah, I mean, that particular thing, you hit it on the head. But the thing is that almost makes it harder is when you have all your suspicions confirmed…"

Mother: … "No, I agree. I agree too. And I think that that's, I think that was what our frustration was because we didn't know what to do, and it just made us feel so powerless. We were at a dead end. And we were just watching you spiral out of control and just banging our heads against the wall. We couldn't keep you in. We tried that and you would leave or you wouldn't come home. And we just… It makes me feel really stupid that I work with at-risk kids every day and I couldn't even help my own son. And that's something that [Boy A] threw in my face every day."

Therapist: "Any response to that?"

At a very basic level, the therapist's questions open up the possibility for reciprocal disclosure and attentiveness. In this and other instances of process modeling, the therapists asked participants to share their thoughts or feelings in response to one another's expressions of emotion. Slowing down the conversation to simple turn taking helps to highlight the importance of open expression as well as listening to one another. Importantly, this is done without stating explicitly that the family needs to work on either of those skills. This is true of a number of coaching turns taken not only by the therapist but by each of the participants.

Consider this mother's comments directed toward her son.

Mother: "No. I think what we are trying to learn, [resident], you know, in terms of how we interact with you too, is that we are asking you to express your feelings and then when you do, we need to just let you do that and not always jump in with an answer or, you know, a piece of advice unless you ask for it. So, I think that's, you know, part of what we are trying, dad and I both, to learn about as well. That's just how we are programmed as your parents, you know? Whenever you mention a negative feeling or problem, then we want to jump in with… 'Well, here's how I would handle it…' I think we just need to not do that unless you ask for it. Would you agree, dear?

Although it is difficult to argue that this mother was aware that she was modeling coaching behavior for the father, we do know that the father is an indirect recipient of the advice. The implication is that within this therapeutic group setting, one does not have to be the direct target of a coaching attempt to reap the benefits. This is an important inference considering the resident received the majority of the coaching in these sessions and that parents were the primary sources of dismissive behavior. I will discuss this in greater detail below for now I turn to a discussion of what it is that is being coached.

The Coaching Topics

A natural question to ask about emotion coaching is, "what is being coached?" The simple answer to that question is that coaches are attending to the skills of emotional competence (Saarni, 1999). The skills of emotional competence include (a) an awareness of one's own emotional state, (b) an ability to discern others' emotional state, (c) the ability to use the vocabulary of emotion, (d) the capacity to be empathetic and sympathetic, (e) the realization that inner experience and outer expression do not always correspond, (f) the ability to self-regulate (i.e., control or temper emotional response), (g) an awareness of interpersonal structures (i.e., rules, roles, norms), and (h) the capacity for emotional self–efficacy in accord with one's moral sense (i.e., the achievement of goals during emotional interaction).

In Chapter II, I introduced the idea that in attending to one skill, a coach can have significant if indirect implications on several others. For example, the question "…what does your mother think about the situation?" might most specifically be linked to the ability to discern others' emotions based on situational cues, but, awareness has

implications for empathic and sympathetic capacity. Empathic capacity has implications for one's relational awareness, and relational awareness, in turn, has implications for self-efficacy. In most cases, the participants in this study seemed focused on the very basic skills of emotional competence including awareness, expression, use of an emotion language or vocabulary, and self-regulation. The implicit links between these skills, however, suggest that the work done on these basic skills can provide far-reaching benefits. Attention to the skills of awareness, expression, and emotion language usage were fairly well documented in exemplars provided above. In the examplar provided below, we can see the father asking about the resident's development of self-regulation skills.

> Father: "How. How are you trying to deal with situations that you do not think are fair to you, or situations or people that you would prefer to not have to deal with, or… I mean what kind of coping skills are you… are you learning any ways of trying to live with that situation?"

The father is merely asking the resident to articulate his own coping mechanisms here. As discussed above, one of the goals of qualified advice giving is to help those being coached to find a balance between being willing to ask for help, and being prepared to advise themselves. Attention to self-regulation, in this instance, can be linked with issues of relational awareness in that part of the resident's frustrations are tied to his interactions with other people (e.g., his roommates, as indicated in previous speech turns). His role as a roommate carries with it expected rules and norms for interaction including the regulation of his anger. His father's final question in the speech turn presented above directs attention to the issue/skill of self-efficacy. The comment seems to suggest that if the resident expects to achieve some level of satisfaction in the relationship

he has with his roommates, he will need to adopt or adapt coping skills that allow him to self-regulate.

The Character of Coaching

The basic components and extended descriptions of emotion coaching behavior help to characterize the enactment of the philosophy outlined by Gottman (1997) and his colleagues. If asked, I would describe coaching as asking questions, leaving an opening for the other, listening to the response, and providing some kind of guidance, often implicitly. Importantly, coaching can be described as a constitutive process, confrontational but open to qualification. Coaching in the therapeutic environment recognizes progress but asks for continued diligence. In the process of coaching there seem to be indirect and implicit ripple effects at work, both at the level of the skills being coached and among the individuals who are involved.

Coaching can be invisioned as the overlapping spheres of its basic components. Based on the evidence provided in this discussion, I argue that these basic components are enacted within a problem-solving frame in that coaches appear to accept emotional experience as a point of engagement with their social worlds rather than a point of departure from it. In the absence of any one of these components, a speech turn becomes dismissive of emotion.

Emotion Dismissing

In continued response to research question one, I will characterize here the kinds of behaviors indicative of dismissive responses to the expression or discussion of

emotion. For the sake of parsimony, I will use dismissing or dismissive as the general term for behaviors that fall within the subcategories of dismissing, disapproving, and laissez-faire responses according to Gottman (1997).

This bifurcation of emotion response types (i.e., coaching or dismissing) is consistent with the extant literature. In effect, dismissive responses, broadly speaking, are responses that lack at least one of the basic components of a coaching type of response. In many cases, each subcategory is indicative of missing a particular coaching component. I begin with the dismissing subgroup. See Table 13 for a summary and comparison of the philosophy and behaviors.

Dismissing Responses to Emotion in Interaction

Each of the dismissive subsets fits rather well with the Gottman's (1997) descriptions of the philosophy. The dismissing responses exhibited by the participants in this investigation tended either to demonstrate a lack of awareness that suggested an absence of listening behavior or offered advice that suggested simply moving past the emotion. Interestingly, and this is true of the disapproving category as well, participants were also often dismissive of their own emotions. Each of these themes is addressed below.

The importance of awareness, as demonstrated in the discussion above, is that it has an impact on whether an expresser of emotion feels as though his or her experience is accepted or acceptable. Without acknowledgement of an expressed emotion, it can be difficult to develop a sense of trust in the experience or in the respondent as a valuable, informed, or qualified source of advice regarding emotion regulation. In the example

Table 13 *Comparison of Dismissing Philosophy and Behavior*

Dismissing Philosophy Description Gottman (1997)	Dismissing Behavior Description
-Treats children's feelings as unimportant, trivial -Disengages from or ignores the child's feelings -Wants the child's negative emotions to disappear quickly -Characteristically uses distraction to shut down child's emotions -May ridicule or make light of a child's emotions -Believes children's feelings are irrational, and therefore don't count -Shows little interest in what the child is trying to communicate -May lack awareness of emotions in self and others -Feels uncomfortable, fearful, anxious, annoyed, hurt, or overwhelmed by the child's emotions -Fears being out-of-control emotionally -Focuses more on how to get over emotions than on the meaning of the emotion itself -Believes negative emotions are harmful or toxic. -Believes focusing on negative emotions "will just make matters worse" -Feels uncertain about what to do with the child's emotions -Sees the child's emotions as a demand to fix things -Believes negative emotions mean the child is not well adjusted -Believes the child's negative emotions reflect badly on their parents	-Focuses attention on behavior over emotion -Suggests emotion is a distraction from real issues -Unqualified opinion is offered- fails to demonstrate an understanding of the others point of view -Fails to provide evidence that she has listened to the other -Places herself at the center of the comments-advice -Addresses someone other than the source of the expressed emotion -Suggests one get over the bumps in the road, but offers no advice about how -Suggests that guilt is not enough without remorse -Tells other what emotion he is feeling as opposed to asking -Suggests that one get rid of emotions -Suggest that one should distract yourself with things that make you feel better -Contrasts emotion with rationality -Rely on your higher power-to get you through your emotions -Changes the subject -Asks a resident about emotions and then asks Therapist if resident is telling whole story -Suggests one should "Deal with it" -Suggests one should "Move on, get over it" -Suggests one should "Just wait the emotions out" -No response offered -Describes others behavior/attitude as selfish

Table 13 *continued*

Dismissing Philosophy Description Gottman (1997)	Dismissing Behavior Description
-Minimizes the child's feelings, downplaying the events that led to the emotion - Does not problem-solve with the child; believes that the passage of time will resolve most problems	-Describes waiting for emotion to go away so he can see things as they really are -Jokes off emotion with other -States he is uncomfortable sharing emotion -Describes coping skill as avoidance -Offers a qualified expression-"it's not a big deal" -Expresses fear of ridicule if he were to express remorse so he won't -Suggests "I just have to stop reacting this way" -States he is not the kind of person who expresses emotion publicly -Asks, "Why stir the pot" -Suggests one should not worry about what you can't change

provided below, the father seems unable or unwilling to acknowledge his son's experience of time at the RTC.

Father: "Why were you so down?"

Resident: "Um, I don't really know. I wasn't like down, it was just like I was tired and um… just like a little depressed just about everything just because like… I don't know, just because of like when I was sort of setting my goal to grad, like I mean June's a long ways away, but it's not like a long stay, it's still, it's just a long time to think about it, but it's just that's my goal."

Father: "It sounds like it's very doable."

Resident: "Yeah, and I mean like, um, it's just like a while away, and like I've already been here for a while and like it just sort of stinks to look at the future, just only how long it's going to be like four or five more months."

Father: "Sure. It probably does. But what's four or five more months, honestly? You're probably there for at least three, right?"

Resident: "Yeah."

Father: "So, what's one more… I mean I'm not trying to be facetious, but I mean, you know, one more month out of your life as if it's going to make a huge, tremendous impact. It's time well spent to me."

Resident: "Yeah, I mean it's not a big deal. It's just that I like… just like the time I've been in treatment too. It's just is like really depressing to look at because it's like I've already been in treatment almost eight months."

Father: "M'hm."
Resident: "And like that's a long time."

Father: "Yep."

Resident: "And like it's going to be around a year when I get out and like I'm really hoping it's going to help me, but like I know it's going to, but just looking at it it's like, oh, it's such a long time."

Father: (chuckles)

Resident: "Because like I mean it might not be a long time for you guys, but like I mean it is for me just because like I'm only fifteen and like…and like, yeah, one year out of the fifteen years, like I was just in wilderness camp and then a treatment center."

Father: "Right. But the flip side of that would be where would you be if you hadn't spent that year?"

Resident: "No where good."

Father: "I mean look at it from that side too."

Resident: "Yeah."

Beyond asking why his son is "…so down" the father does not address the "depression" the resident is experiencing. It seems as though the resident attempts a number of times to describe his experience, and the father continually misses opportunities to recognize that. Eventually, the resident begins to waver, claiming, "Yeah, I mean it's not a big deal. It's just that I like…" Without affirmation from his father, the resident seems to question whether or not the emotion is appropriate or acceptable. The father appears wholly unaware of the emotion and his influence on the resident.

In this case, using vocal fillers did not appear to indicate active listening so much as simple conversation tracking in preparation for his speech turn. The father's failure to address the resident's emotion before pointing out the positive aspects of being enrolled at the RTC seem to suggest a lack of listening as well. Similarly, the mother in the example below seems to be preoccupied with defining her son's sexual orientation and misses an opportunity to respond to his expression of shame.

Resident: "Um, we were all, we were all at a park and there was like five or six of us and, um, it was, it was that he was gay and, I don't know we kind of just started making out…"

Therapist: "Keep going."

Resident: "And then that, and then after a couple of minutes I stopped and kind of just like collected myself in a way and like just went and like sat by myself for a while. Partly because I was shocked and also because I was ashamed of myself."

Mother: "Did you do that because you thought you might be gay?"

Resident: "No."

Mother: "Do you know why you did it?"

Resident: "No."

In subsequent speech turns the therapist returns the focus of the conversation to the resident's shame. Until that point, however, the mother does not address the emotion. The apparent absence of the awareness and listening components of coaching behavior in these and similar interaction sequences were indicators of dismissive behavior.

Dismissive behavior also included attempts at advice giving.

Stepfather: "Well, you know… Once you clean and rid yourself of all the past things, then anything else like here or whatever, weed or whatever, you don't even have that no more."

Mother: "Mm. Mm. Not at all."

Stepfather: "You don't even have it no more. It's a better high for you to get out there and set out to go apartment shopping or whatever, do you know what I'm talking about? Completion. Some positive completion."

Resident: "Yeah."

Stepfather: "So, once you get rid of yesterday's woes, then you begin to rebuild. Once you do that, it's unreal, man."

Although it seems clear that the advice is well intended, it does not offer much in regard to dealing with emotion. The advice is simply, "…get rid of yesterday's woes…".

The problem, of course, is that without coping with or processing through the emotions in some way, it is difficult to move on from them. The same is true in this next example.

> Father: "Well, you know, we talked about that very thing the last time you were home and I told you just about exactly that. I said that people move on and I mean everybody no matter where you are has to get used to meeting, knowing people and then people move away. People get different jobs, uh, going to college, you say good-bye to close friends you've had for four years and you may never speak or see them again. It's just the way it is. And you've got to learn, I mean it hurts, but you move on and rather than freak out about it when the time is coming close you have to just, you know, it's okay to be sad about it everybody, everybody goes through that. But, you know, life goes on. There's lots of other people in the world. There's no shortage of that and, you know, its, you just move on from that. Everybody has to go their separate ways eventually. We talked about that we talked about…and that was pretty much what I said. Is that right [resident]?"

Advice to move on and get over it is essentially no advice at all. It suggests that the emotion is unnecessary or unimportant, so not only is the opportunity to provide real guidelines for emotion regulation lost, but there is also the implication that the emotion expressed is invalid.

It was not uncommon to find participants, typically residents, dismissing their own emotions. In the example provided below, the resident is responding to his father's question about how he copes with frustration.

> Resident: "Yeah. Um, I'm used to not getting recognized, so it's kind of like I kind of go out of my way sometimes to do it… Where I mean I'll obviously get recognized if staff are right next me or somewhere that staff can see that I'm doing something to try to correct some negative behavior. When I'm kind of just like overlooked or feel like I'm

> mistreated or unjustly accused of doing something, I just kind of rub it off and just say like it's not a big deal, things are going to happen, and I guess I kind of minimize it in my head saying it's not a big deal. I have a tendency to blow things up until they are really huge, and I think I've just screwed up so bad that there's no point in even trying anymore. So, I kind of think about it and then I minimize it and then once I'm not as angry or pissed off, I just kind of think about it with a clear mind and tell myself what it really is and how bad it really is."

The resident's response indicates that he copes with his anger by minimizing it and waiting until he has a "clear mind" to determine "how bad it really is." There are two important inferences to be drawn from this exemplar. First, for the resident, dismissing his emotional experience through minimization techniques such as, "rub[ing] it off" and "saying it's not a big deal" are taken for granted coping skills. And second, the resident's response suggests that to him, emotion and rationality are antithetical. He needs a clear mind to determine how bad things really are.

The taken for grantedness of this response is a clear indication that this is a philosophical commitment, or a meta-emotional structure (Gottman et al., 1996) that has been nurtured for him over time. For this resident dismissing by minimizing is an appropriate way to handle anger. This very nonchalant response is important to note because it brings to the foreground that dismissing and perhaps more importantly, the disapproving speech turns discussed below, are not always uttered in a spiteful or derogatory way. In combination with the earlier discussion of confrontational coaching, we can begin to see an important contribution of this investigation. In interaction, coaching and dismissing are not differentiated by either a supportive or critical tone.

The second important point raised by this exemplar is the issue of emotion versus rationality. Although I will address this in more detail below, it seems important to note

that when emotion and rationality are cast as opposites, there is an inherent dismissal of emotion as useful or even trustworthy. The resident in this example says himself that he waits until he has a "clear mind" before he makes a determination about the importance of the issue that he became angry about in the first place. If the assumption is that emotion is irrational, then the anger the resident experienced could not have provided him with any useful information. On the other hand, if emotion is viewed as manageable and not separate from the ability to reason (Fonagy, Gergely, Jurist & Target, 2002), then we are open to the possibility, as Planalp (1999) suggests, that emotion provides us with information about what is most important to us. I turn now to the second form of dismissive behavior, disapproving.

Disapproving Responses to Emotion in Interaction

Like dismissing messages, disapproving responses were likely to be delivered in a casual and taken-for-granted manner. Participants disapproved of their own emotions, and, as with instances of dismissing behavior in this investigation, there were disapproving responses linked with the assumption that emotions are irrational. The distinguishing characteristic of disapproving responses, however, is the very apparent absence of the acceptance component of coaching. Table 14 provides a comparison of disapproving behavior with the philosophy.

The lack of acceptance indicative of disapproving responses invariably frames the recipient's emotional experience and expression as invalid. The overarching theme to the philosophy and in the behaviors observed among these participants is that the emotions

expressed in these instances should not have occurred. Consider this exchange between a father and son. Notice the apparent reciprocation of philosophy between the two.

> Father: "For me, I have learned a valuable lesson in these last five years. The way that I deal with a lot of these situations now is I simply say, 'Grant me the serenity to accept the things I cannot change.' I'm sure you've heard that before, and we all have, but as simple as that sounds, for me, personally, that's made a big difference many times. Instead of opening my mouth, which I do too often and too quickly, many times I've been able to keep it shut and just say, 'You know there is nothing really I can do about it and so why stir the pot and cause myself more aggravation by trying to change something that I really can't.'"
>
> Resident: "M'hm."
>
> Father: "So, I thought I'd put it out there for what it's worth."
>
> Resident: "I understand. Not so much with things that like… problems that I have… it depends, like it's not all the time, but with certain people I have a really hard time keeping my mouth shut. If someone says something that really pisses me off, then usually before I can stop myself I say something that is really stupid that will get me in trouble. I don't have a huge problem with that, but with certain people I have a really high tolerance just to kind of explode and let my anger out on them because they are like the exact kind of person that I can't really stand to be around and yet I'm forced to be on the same team and in the same room as them. And it is just like sometimes I can control myself and just ignore it and not explode or say something stupid, but other times it's just that when other things are on my mind or depending on what the situation was, if it's early in the morning and he says something that I think is outrageous, I'll just say something really dumb. I struggle with it, but it's definitely gotten a lot better than it was. When I first came here, I would explode on anybody just because if I got pissed off, I felt like it was my right to cuss at them and say whatever I felt I was feeling because like if I'm feeling pissed off and feeling like I want to beat someone's ass, then that is what I'm going to say, and I didn't think there was a problem with that when I first got here.

Table 14 *Comparison of Disapproving Philosophy and Behavior*

Disapproving Philosophy Description	Disapproving Behavior Description
-Displays many of the Dismissing Parent's behaviors, but in a more negative way -Judges and criticizes the child's emotional expression -Is over-aware of the need to set limits on their children -Emphasizes conformity to good standards or behavior -Reprimands, disciplines, or punishes the child for emotional expression, whether the child is misbehaving or not -Believes expression of negative emotions should be time-limited -Believes negative emotions need to be controlled -Believes negative emotions reflect bad character traits -Believes the child uses negative emotions to manipulate; this belief results in power struggles -Believes emotions make people weak; children mist be emotionally tough for survival -Believes negative emotions are unproductive, a waste of time -Sees negative emotions (especially sadness) as a commodity that should not be squandered -Is concerned with the child's obedience to authority	-States that other should not feel the way he feels -Describes other as no different than a "million" others -States that other's expression is inappropriate without providing qualification or guidance -Responds to expression with derogatory laughter -Describes herself as uncomfortable with and unwilling to "deal" with other's "negative" emotion -Suggests that anger should be controlled – "Learn to keep your mouth shut" – Suggests this is a positive change -Tone is critical of emotional expression and attempts at coping -Suggests that self is "Not supposed to be angry" -Suggests that others should not get the privilege of feeling bad for him -States that others "Do not have the right to have emotions about him" -Uses directive questioning regarding rule breaking –tone seems interrogative -Tells other that "The way you act[express emotion] is unattractive" -Tells other "You should feel like…" -Directs attention to good behavior disregarding emotion -Advises that "You can't fly off the handle…" but does not provide alternative solutions

> Father: “I’m glad you’re learning these lessons now because I didn’t, and I learned a lot of these lessons at work and I paid the penalty for it. Because, you know, when you are working with people everyday, the same thing happens on the job and my mouth would start going, saying sarcastic, nasty things every once in a while. I didn’t know it at the time, but looking back on it, those things got me into a lot of trouble just because I couldn’t control my mouth. It’s an ongoing battle that I still have to fight, and I think a lot of people do, and think a couple of times before I speak and open my mouth. I still make mistakes, but I think I’m doing better. I’m far from perfect. I think you’re fortunate you’re in a situation where you’re learning it now and I didn’t learn it until I was well, well along on my way in my career. I probably hurt myself pretty significantly throughout my career by just not realizing what I was doing and not being able to control that impulse to say something wise or nasty. So, for what it’s worth, I’ll put that out there.”

In the preceding example, the father and son share their disapproving philosophies. It appears clear that the resident believes the most important part of emotion regulation is control. Neither the resident nor the father spends time here talking about exploring the anger, the root of the problem, or coping skills other than, "keeping my mouth shut. " Again, whereas one might expect disapproving speech turns to sound disparaging, in fact, the participants are quite happy with themselves. The father praises the son, "I'm glad your learning these lessons now." What seems important to remember is that to these participants, this is progress, this is appropriate. The resident and father believe they are conforming to societal standards of emotional expression and therefore successful. The problem, however, remains that actual coping mechanisms are underdeveloped. The issue of skill development is at the heart of the final dismissing category as well. I turn to that next.

Laissez-Faire Responses to Emotion in Interaction

The laissez-faire response style is characterized in Table 15. But, as suggested above the most distinguishing characteristic of these kinds of responses is that the advice giving component of emotion coaching behavior is missing. Gottman et al. (1996) describe holders of this philosophy as comfortable, even encouraging of emotional expression but either unable or unwilling to provide guidance or advice. The sentiment of the philosophy is that emotions will pass once expressed. Although this would seem to make these kinds of responses easy to spot, in fact, they were often the most difficult to distinguish. There are two reasons for this.

First, a good deal of the coaching behavior observed in these therapy sessions was, as described above, implicit. This sometimes made it difficult to decide if a given turn was coaching by leading participants toward open expression, attempting to raise awareness or demonstrating acceptance and simultaneously coaching those behaviors. At other times, it was difficult to distinguish laissez-faire messages from dismissive messages because it appeared there was a lack of awareness of emotion from the respondent and therefore a simple dismissal. Ultimately, the decision to categorize a response as laissez-faire was based on the issue of advice giving clarity. Where there was clearly no attempt to offer advice, the response was categorized as laissez-faire.

In the example below, the resident has become angry with his parents when they disclosed that they have been reading his mail.

Table 15 *Comparison of Laissez-Faire Philosophy and Behavior*

Laissez-Faire Philosophy Description	Laissez-Faire Behavior Description
-Freely accepts all emotional expression from the child -Offers comfort to the child experiencing negative feelings -Offers little guidance on behavior -Does not teach the child about emotions -Is permissive; does not set limits -Does not help children solve problems -Does not teach problem-solving methods to the child -Believes there is little you can do about negative emotions other than ride them out -Believes that managing negative emotions is a matter of hydraulics; release the emotion and the work is done	- Tells other "Do whatever you want" -Provides support but not advice -Demonstrates understanding of others perspective -Affirms the expression of emotion -Does not appear to set a firm limit on expression -Expresses that emotion will pass with time -Suggests that "Emotions don't need to be dissected… just move through them" -Suggests that others feelings are valid but really offers no advice -States that others feelings are "perfectly fine", offers no advice -Supports and accepts an expression, but offers no feedback, no guidance -Encourages expression but no advice offered -Accepts and comforts expression of difficult emotion, does not offer guidance, does not explore the emotion -Provides evidence of listening in a recap asks for confirmation but offers no advice

Mother: "Well, I just wonder if it would help to take a break here."

Therapist: "M'hm."

Mother: "You know. For you to go back to the unit a little bit and we have til what time tonight?

Father: "9."

Mother: "Okay. So you know you could take some chill time and come back and go out for dinner and maybe you know, as we said a movie is not a highly communicative thing but…"

In subsequent turns, the therapist suggests to the resident that if he decides to return to the unit,[20] that an expectation of the therapist's would be that the resident talk with a peer about the emotion (i.e., betrayal) he expressed during this exchange with his parents. For the parents, however, the cooling off time is the extent of their advice. The apparent expectation is that by the time they meet for dinner, the emotion, and therefore, the problem will have passed. This interaction clearly demonstrates the "hydraulic" metaphor aspect of the laissez-faire philosophy.

In this next example, there is a clearer demonstration of an accepting/supportive response followed by no advice giving.

Resident: "Yeah. Thanks Mom. And it's good to know that, I mean, I mean I'm doing it like, uh, because like I need to do it and like it's something for me. And, you know, because like after that talk with [Female A] like that was, and the crack on my head and I talked to [Female A], like it all kind of came to me that like, yeah, this is going to help me on down the road and like… I mean, I don't know what it was, like it's just like for some reason like I just keep getting more confident each and each day and doing better and it's nice to know that that's something like that I didn't feel earlier that, you know, that you care that much."

[20] The "unit" is the term used by resident's and staff of the RTC to refer to the dormitory or residential area of the facility.

Mother: "Oh, I'm sorry you didn't, I'm sorry you didn't feel, you didn't know that. I'm sorry you had, that you felt that way. Because we've always wanted just the best for you kiddo, wanted you to do your best."

Resident: "You know, that was, that was really like hard for me to admit a lot because I wouldn't, I wouldn't even look at myself as very time, worthwhile, you know?"

Mother: "Aww. So you got that all from talking with [Female A] that day we were flying?"

Resident: "It helped me…"

Here the mother is clearly aware and seems to accept a rather significant expression of low self-worth from her son, but, she appears to essentially drop the conversation there. Her subsequent turns begin to close the session. There is an opportunity missed here to explore how or why the resident reached a point where he felt his parents did not consider him "worthwhile." The mother's response seems to suggest "I'm glad you've moved past that."

I offer one final point about laissez-faire messages anecdotally. In the process of developing rapport with residents, I have seen therapists and milieu staff allow their clients to "vent." This seems more apparent in the first few interactions than at any other time during the resident's enrollment. One possible explanation for this is that this is an extended demonstration of acceptance. If we begin to think of the expression of emotion as an expression of individualism or individuation, then acceptance or recognition of that individualism becomes a foundation for a relationship between these two parties. The argument then is that a laissez-faire type of response, might be strategically used to help establish a relationship between an interventionist and his/her client. This stands as a potential topic for future research however.

The Character of Dismissing

On a relational level, dismissing, disapproving, and laissez-faire messages seem to suggest to their recipients that they have made a mistake in expressing or trusting their emotions. These messages carry very little or unqualified advice about the regulation of emotion and, therefore, offer very little guidance for improving self-efficacy in emotion-filled interactions. It is important to note the taken-for-granted nature of these messages in the conversations recorded for this investigation. They were offered sincerely and seemingly with the best of intentions. For thoughtful parents poring over parenting guides, an easy but misguided interpretation to make about coaching and dismissing philosophies is that one is "nice" and the other is "mean." In actuality, it appears that the enactment of either philosophy is equally likely to *sound* supportive or nice.

The examples of the subcategories of dismissing behavior demonstrate the importance of messages that include each of the components of a coaching response. The absence or presence of these components seems to determine the degree to which recipients of these messages can trust and understand the function of their emotional experiences. In answer to research question one, it appears that the descriptions of the meta-emotion philosophies offered by Gottman et al. (1996) are reflective of the kinds of communicative responses enacted in conversation during family therapy sessions with adolescent males.

Profile of Meta-Emotion Behavior

In this final section of Chapter V, I will address Research Question 2 which asks: What is the profile of adolescent, parent, and therapist Meta-Emotion Behavior (MEB)

across the phases of therapeutic intervention for struggling teens? In addition, I will respond to Research Questions 4, 6, and 6(a) which are essentially subparts of Research Question 2. Responses to these questions will cover the general tendencies in the coaching and dismissing behavior of each participant, consider the resident's prominent role as both the source and target of emotional expression and discussion, and explore differences in Meta-Emotion Behavior according to the kinds of emotions expressed or discussed. I begin by describing the communicative behavior of the therapists.

Therapist MEBs

The therapists who participated in this investigation overwhelmingly responded to emotions with coaching MEBs. In fact, of the 173 therapist responses tracked, only 7 were coded as dismissive. I reported in Chapter IV that therapists were the least likely participants to be the sources or targets of emotion during these sessions, but they were the most likely to respond to emotion. Therapists responded more often than mothers (76) and fathers (58), the second and third most likely respondents, combined.

The frequency with which therapists responded to emotion and infrequency with which they responded in a dismissive style seems somewhat intuitive. Some research has suggested that parents with higher levels of education and those who have engaged in "parenting" training have scored higher on measures of coaching meta-emotion philosophy (Hakim-Larson et al., 2006). It seems likely that their professional training and experience equip the therapists to respond to emotions in a way that demonstrates awareness, listening, acceptance, and guidance. Nevertheless, there were instances of dismissing. I will address those here.

There were instances were it appeared that the therapist failed to monitor the communicative process. That is, there were portions of conversations that, although focused on the resident topically, excluded the resident from participation. Essentially, the therapist and parents discussed the resident's inability to regulate emotion as though he was not there.

> Mother: "I guess [therapist] what I don't understand is, um, bear with me here, I mean is it normal to just ask them if they think they should get a consequence and then if they say no, they don't get one or is [resident] not telling us the whole story?"
>
> Therapist: "No, what I asked [Resident A] was I said, 'what do you think would be an appropriate consequence for this type of behavior.' And he said 'I think giving up a phase is appropriate.' Um, when I turned to [resident] he didn't answer and so I said 'you know what, I, because you are violating my trust, ' I mean this isn't the exact words I used, but 'because this is violating my trust I'm frustrated, I'm having a hard time not taking this personally and so I'm going to end our session and we will talk about it some more later.'"
>
> Mother: "Okay."
>
> Therapist: "Um, so I think what [resident] is leaving out is the discussion that we had today, um, and that for me it's not so much about the phases or the consequence, it's how [resident] is reacting to this, which was to immediately get into repair mode, which was apologize, write me an apology letter, tell me how sorry he is and he's gonna fix it. Um, and then until I brought it up again, you know, I said 'well goll how was that, what was that like to see [Resident A], your friend,' uh, you know, 'who said this is an appropriate consequence for me and you didn't even respond?' That seems very, fairly selfish, um, to which I got, in my opinion, a pretty snide response and [resident] attempted to take his bracelet off, bracelet off in a dramatic fashion that seemed self-pitying and I said 'no, I don't want it.' Cuz at that point it's not about the phase or the bracelet or anything, it's about how he's conducting himself and how he's dealing with all this stuff and I think its pretty similar to how he would do things with you guys. Um, so for me I really wasn't stuck so much on the phase loss or all that as much of the behavior and we talked about the relationship that he has and, um, you know, I, you know, he's, you know, I guess I'm a little bit

> worried because this was a positive and healthy relationship in my opinion, but he is starting to point out, view it in a somewhat codependent manner. And so…"
>
> Mother: "Are you talking about the relationship with…?"
>
> Therapist: "with [Resident A]."
>
> Mother: "[Resident A]. Okay."
>
> Therapist: "I mean even responding this way in self-pity way the, you know like I said well 'what does this mean?' and he said, well what did you say [resident]? What does it mean? Are you paying attention?
>
> Resident: "Hm."

Although to some degree, this is a sequence that is based on making clarifications for the mother, the exclusion of the resident seems to result in his inattention to the conversation. Any benefit that might have been gained by the resident from the therapist's turns is lost. The likely inference made by the resident is that he is not viewed as capable of participating in the conversation.

Other instances of dismissing by the therapists included offering unqualified advice (i.e., telling a resident what emotion he was experiencing rather than asking) and demonstrating acceptance without offering advice (i.e., laissez-faire responses). There are two important points to make here. First, in each of these cases, the response offered may have been therapeutically indicated. That is, it may have been useful, helpful, or therapeutic for the therapist to respond the way he did. For example, naming the emotion for the resident may have been a necessary step toward addressing a more pressing need. As discussed above, it is not uncommon to see therapists and/or milieu staff offer moments of venting uninterrupted by advice giving to establish a general sense of

acceptance for the resident. The implication here is that strategic use of dismissive responses to emotion may be an effective technique in the broad scope of an emotion education.

The second point worth mentioning is that the evidence provided here helps to support the Gottman et al. (1997) assertion that an individual's meta-emotion philosophy is not manifest in a single utterance but rather in the preponderance of his or her speech turns (i.e., Meta-Emotion Behavior). This will become an important issue as I discuss parent Meta-Emotion Behavior below. For now it is sufficient to say that for the therapists who participated in this investigation, responses to the discussion or expression of emotion typically included each of the emotion coaching components discussed above.

Dismissive responses from therapists were present in each of the phases except the test phase and in each case were directed to the residents. Coaching responses from the therapist were almost exclusively directed to the resident. Parents often became the indirect recipients of the therapist's advice, but it is difficult to say that there were specific detectable patterns to that behavior.

Direct coaching of parents seemed to be offered in reflections of and probing for the parents' emotional responses to their sons' behavior. That was the case in the following example.

> Therapist: "Okay, well, I guess I just want to clarify, because maybe I'm misinterpreting or maybe I'm misunderstanding what's being said. It sounded like the term 'put the brakes on you,' um, I interpreted that as your mom saying that 'I didn't set more limits,' or say, 'No, [Resident], you can't do that.' That… and… I guess that's what I'm… [Mother], is that what you're meaning?"

Mother: "Yeah. And I think what I did was I made superficial inconsistent efforts to show him where his boundaries and limits were. Because if he gave me a hard time about something, I just gave up and gave in too easily when, you know, maybe he needed me to be, um, more proactive and more definite and, um, and to have more follow through that I didn't because, you know, maybe I was tired or distracted or, you know, for varying reasons. I think [Resident] has very strong, he's strong willed, and I just, I just felt that he would always have more energy to put toward getting what he wanted than I had to, um, make sure it was always the right thing. Am I making any sense?"

Resident: "Yep. You're making perfect sense."

Mother: "I felt like you could outlast me, and so sometimes I might have, you know, maybe more than sometimes, maybe often, I just gave in and gave up before I should have."

Resident: "You've told me this before."

Therapist: "[Mother], it sounds like there's some guilt maybe? Like if only I maybe would have outlasted [Resident] this one time or something that things would be different? Is that the case?"

Therapists responded to expressions of Anger, Sadness, and Fear more often than any other emotions. Understandably, therapists did not respond to expressions of Love, but, it is somewhat curious that therapists did not often respond to expressions of Joy. One possible explanation is that parents and residents did respond to expressions of Joy and did so with coaching Meta-Emotion Behaviors. It may have been less "necessary" for therapists to coach expressions of Joy. Therapists' Meta-Emotion Behaviors did not vary by therapeutic phase.

A final point regarding therapist responses to emotion has to do with the issue of rationality. There were a number of occasions when the participants compared emotion with rationality. The comparisons were not emotion specific but rather "emotions" or "emotional reactions," broadly speaking, were often discussed as generally or broadly

irrational. The problem with describing emotions as irrational, as was discussed above, is that it becomes difficult to trust the validity or utility of the emotions one experiences. One therapist made distinctions between emotion, rational thought, and action. His advice is offered below.

> Therapist: "Yeah, and, and, you know, those are emotional responses that get in the way because of thinking errors. So, the thinking error is… could be black and white thinking, or perfectionistic thinking, you know, don't let those get in the way because they're going to create these emotions, 'Aww, man, I'm…' or 'I'm screwed, I can't do anything about it.' 'I'm already wet…' like your dad said, 'my shoes are wet…' Those are just thinking errors that create emotional responses, and keep both of those things in the back of your mind so that you understand that, you know, 'I can easily correct this by just shifting my thinking around. I can change my emotional response by shifting my thinking.' It's that simple."

This is the clearest distinction made across the recordings regarding the relationship between emotion and rationality. The therapist suggests here that the resident's thinking is/or may be irrational. In turn, the resident has an emotional reaction to that thinking that often reinforces the irrational thought which creates a negative cycle that can be difficult to break. Although emotion may contribute to or reinforce irrational thoughts or behaviors, it should not be thought of as the source of irrational thought. This is an important distinction to be made, and, it seems to have been left unclear in other sessions. Perhaps one of the contributions this research stands to make is in suggesting to the RTC practitioners the importance of clarifying the relationship between emotion and rational thought.

Mothers' MEBs

Mothers were the second most likely participants to respond to the expression or discussion of any emotion. Mothers offered more responses during the Apply phase recordings than at any other phase. Without regard to emotion, more than half of mothers' responses were coaching. This was true in each phase except for the recordings from the Apply sessions which were approximately 70% coaching. The highest proportion of dismissing responses from mothers, regardless of emotion, occurred during the impact sessions. Here just fewer than half of the responses were dismissive.

Sadness and Anger, respectively, drew the most frequent responses from mothers across all sessions. The only emotion more likely to be dismissed than coached by mothers during these sessions was Sadness. This occurred most frequently during the impact sessions and was nearly 50/50 across each of the others. In fact, removing mothers' responses to sadness, their Meta-Emotion Behavior was nearly three quarters coaching. This finding suggests that meta-emotion philosophy and, in turn, Meta-Emotion Behavior may differ according to emotion. Continued research would help to determine the legitimacy of this claim and perhaps shed light on the extended implications for emotion regulation and/or emotional (in)competence. It is unclear why sadness was dismissed more than other emotions. It did not appear that mothers "disapproved" of sadness, which would suggest a lack of acceptance. Rather, mothers seemed to argue that it was an emotion that should or could be gotten past with time. Unfortunately, however, many responses offered no real guidance about how to do that.

That was the case in the example provided below. Here the mother is responding to her son who has suggested he feels down when he thinks about his future.

> Mother: "Like I said you just take one day at a time. And you're a teenager, you're a kid, you're going to make mistakes, but don't, once you start falling, don't keep snow, don't snowball. Just get up and start over again and, you know, keep going in the right way."

While the number of responses to emotions did decrease according to therapeutic phase, mothers' responses did not demonstrate a radical shift in proportions of Meta-Emotion Behavior according to therapeutic phase. This suggests that the meta-emotion philosophies of the mothers in this investigation did not shift with phase advancement. This is, of course, only an indirect measure of change, but it is an important indicator nonetheless. Although mothers generally offered more coaching than dismissing messages, they also contributed the highest number of dismissive messages (29) from any type of participant. Mothers did not respond to expressions of emotion from the therapists and only very rarely from the fathers. Responses were almost exclusively directed at the resident. Having described the general profile of mothers' MEBs, I turn now to a description of the fathers who participated.

Fathers' MEBs

Like the mothers who participated in this investigation, fathers provided more coaching than dismissing responses to the expression or discussion of emotion. Like the mothers, these fathers were dismissive of Sadness, suggesting the resident should simply "get over it." What distinguished fathers' from mothers' Meta-Emotion Behavior in this investigation was the dismissal of Anger. In fact, fathers' responses to Anger were often

disapproving. Fathers were the primary source of disapproving responses regardless of phase or emotion. In the example below the father is disapproving of continued expressions of Anger from his son.

> Father: "Well, what's even worse is you resorted to the old [resident] where you throw tantrums and fits and put off snotty and sarcastic remarks."

The father clearly disapproves of the behavior but does not suggest a more appropriate way to express it. The focus is on control and discipline rather than regulation.

Fathers' Meta-Emotion Behavior did not vary significantly in proportions of coaching and dismissing across the phases of intervention except for the impact sessions where they were more likely to dismiss than coach. This is likely due to the frequency with which sadness was expressed or discussed during the impact phase recordings. Again, like the mothers, this finding suggests that fathers' meta-emotion philosophies did not shift over the course of the intervention but, rather, shifted with particular emotions. In this case it was both Anger and Sadness. That mothers coached Anger and fathers disapproved of it is an interesting contrast. Fathers and sons appeared to discuss Anger as an issue of self-control and rationality (see exemplar from the discussion of disapproval above). For fathers, Anger appears to have limited utility. In fact, Anger was discussed as a barrier or hindrance to professional and/or social growth.

Fathers' responses were limited to emotions expressed or discussed by the resident. One point of interest stems from the research cited above which suggested that for adolescent sons, the opinions of their fathers were more influential than those of other family members in their identity development (Grotevant & Cooper, 1985). If the existing literature is true and the results here are proportionally accurate with regard to

parental response frequencies, then it could be suggested that the limited contributions made by fathers are quite heavily weighted. Future research might look to the salience of mothers' versus fathers' Meta-Emotion Behavior in the development of their adolescent children's meta-emotion philosophy.

Before moving on to the residents, I want to discuss conversational phenomena related to Meta-Emotion Behavior apparently attributable to group interaction and applicable to mothers', fathers', and therapists' responses in this investigation. It was not uncommon to discover what I am calling "tag-team coaching." I am referring here to instances in conversations where speech turns from individual participants (i.e., mother, and/or father, and/or therapist), when taken separately, provide only some of the components of coaching, but when these speech turns are considered in conjunction with one another, they create a coaching response. Consider the following example.

> Resident: "I'd be like hesitant to play because I don't know if I'm gonna be good or not. So, that's kind a how it is with talking, like, uh, I'm scared of talking cuz, you know, I don't know if I'm gonna like say the wrong thing to the wrong person and have it come back at me somehow?"
>
> Father: "I mean how would it come back at you?"
> Resident: "Um, they would just see it as like a flaw or something and like shoot it back at me, like, uh, make fun of me for it or something."
>
> Father: "Has that happened to you?"
>
> Resident: "Uh…I can't think of a specific event."
>
> Father: "So, so, what, I mean, what is that based on then?"
>
> Resident: "Um…maybe just observations of other people. Maybe I've seen it happen to other people and I…"
>
> Therapist: "I would agree with that. I would say it's based on assumptions."

Mother: "M'hm."

Father: "M'hm."

Therapist: "I think it's based on the fact that you have seen kids be mean. Adolescents can be mean, um, and you're worried that that will happen to you."

Resident: "Yeah."

Therapist: "And, and it really does deal with your self-esteem and, and your self-confidence, your self-worth, all of that stuff. And because you are afraid of that, and your ego strength's pretty fragile; still developing, you don't really want to take that risk because what other people think means a lot to you. That's very normal developmentally."

Resident: "M'hm."

Therapist: "Um, and, and so part of being able to help you with that is to move forward and increase that self-esteem, that self-worth to take those risks, especially to start off small with people you trust the most. And then, as you start to do that, be able to then say, 'Okay, here are the characteristics in someone that I trust, if I see these in other people that then lets me know that maybe this is an okay person too to take a risk with.'"

In this example each component of coaching is demonstrated in the combined speech turns of the father and the resident. The father's use of probing questions demonstrates awareness of emotional arousal and a willingness to listen to the resident, from his own point of view. The therapist describes the resident's emotional reactions as "developmentally normal" demonstrating acceptance. Finally, the therapist offers guidance regarding appropriate steps toward regulating the resident's fears. The "tag-team" approach seems to provide parents with a powerful tool for salvaging individual turns that fail to provide all of the elements of coaching. I turn now to describing the residents' behavior.

Resident MEBs

There are three important themes to address when it comes to the Meta-Emotion Behavior of the adolescent residents who participated in this investigation. First, residents were the only participants who were predominately dismissive of emotion. Second, although the frequencies are low, resident responses seem to indicate different Meta-Emotion Behaviors between the two lower (i.e., Explore and Apply) phases and the two upper (i.e., Impact and Test) phases of intervention. Finally, resident coaching behavior was distinct from the coaching responses offered by therapists and parents. I begin with a description of resident dismissive behavior.

Residents were the source of 41 total responses to emotion. Twenty-four of those responses were categorized as dismissive. Like their parents, residents responded most often to Anger and Sadness, and, like their fathers, these emotions were more likely to be dismissed than coached. Joy was the only emotion that residents responded to with more coaching than dismissing messages. Interestingly, the majority of resident responses were self-directed, that is, residents responded most often to their own emotion as opposed to the emotions of either of their parents or the therapists. Residents may not have seen it as their role to comfort or respond to their parents' emotional expressions. Residents did not appear to be coached towards more active responses to their parents. Therapists seemed to encourage little more than turn taking or the simple reciprocity of emotional expression from adolescent to parent.

Dismissals of their own emotions seemed to be characterized by residents suggesting that their emotions were "no big deal" or unnecessary to express. In this example, the resident suggests that he is not the type of guy who expresses sadness.

> Stepmother: "Dad and I were both really proud of you when you got on that plane."
>
> Resident: "Yep."
>
> Father: "It was hard to leave the airport."
>
> Resident: "It was hard for me. I kept sitting at that airport when we ate that dinner and I was getting really sad, but I kept it in."
>
> Father: "Yep."
>
> Therapist: "You don't need to keep it in. I mean, you can share the feelings."
>
> Resident: "I'm not that, I'm not that kind of person that just starts crying at the airport… I'm going to miss you, dad, I'm going to miss you, [Stepmother]."

This simple dismissal provides a relatively clear view of the resident's philosophy of Sadness. The resident's description seems to suggest that the expression of Sadness serves no purpose and he should, therefore, "keep it in." Overall, residents seemed to express a need to suppress, control, and/or get rid of Anger and Sadness, especially during the Explore and Apply phase recordings.

There is some limited evidence that suggests residents in the Impact and Test phases of intervention were more likely to coach than to dismiss emotion, whereas their counterparts in the Explore and Apply phases were more likely to dismiss emotion. Although the claim should remain tentative, the potential implications are important. These initial results indicate that among the changes residents make during their

enrollment at the RTC, we can include shifts in MEBs which are indicative of shifts in meta-emotion philosophies. Emotion regulation is an important part of the therapeutic process for struggling teens.

These findings also draw attention to the consistency of parent MEBs across the phases of intervention which raises two issues of concern. First, it would appear that adaptations with regard to emotion regulation are local or specific rather than systemic. That is, only the residents appear to have "changed." This calls into question the potential for long-term adaptations once intervening variables have been removed (i.e., the therapist).

The second issue has to do with understanding the proportions of coaching and dismissing behavior which contribute to the development of a coaching or dismissing philosophy. In this investigation, parent coaching and dismissing behavior were recorded at approximately 60 and 40%, respectively. If we assume, based on observed behavior, that residents enrolled at the RTC brought with them a generally dismissive philosophy of emotions, then the recorded proportions of parent MEB appear to contribute to a dismissive philosophy even though parents appear to have coached more often then they dismissed. An important direction for future research would be to draw from a random sample of families not engaged in therapeutic intervention to compare against this group to determine what proportions of MEB contribute to the development of a coaching philosophy.

Finally, I will address the coaching behavior of the adolescent residents. Coaching responses from residents were directed at both themselves and their parents. When

coaching themselves, residents appeared to talk through appropriate steps to regulate a given emotion. In the example below a resident discusses his shift in philosophy and approach toward achieving happiness or joy in his life since arriving at the RTC.

> Resident: "Yeah. I mean, it's definitely… I can see myself before I came here expecting and just not being grateful for anything I have. And the things that I really enjoy, like when I started using drugs, I just found… like that's just me wanting some money and not even earning it. Like, I feel like an idiot now. But, it's something I hadn't done and it's something that I really think I'll enjoy doing, just because I'm always concerned about what I'm going to get or what I'm going to get out of doing a certain thing and then when I don't get anything out of it, I'm pissed off. Like, I should just be happy to help someone out and just to make someone else's life a little bit easier. Like, that's the way I find it now. When I came here, I would always try to take every opportunity I could to just kind of make myself look good, and now I kind of find myself stepping back and helping others kind of get the life for them a little bit. When they're struggling, I kind of give them… whatever might help them feel better about themselves or might help them get recognized for a good intention…"

The resident offers up a continuum of progress in his incorporation of joy in his day-to-day life. It is important to note that resident coaching behaviors were somewhat distinct. For example, in coaching the self, the acceptance and listening components seem to be assumptions unnecessary to demonstrate. Nonetheless, the resident identifies appropriate steps to take or that he has taken to regulate his experience of Joy. There were also idiosyncrasies in resident coaching behaviors directed towards their parents.

Although residents were unlikely to respond to their parents' emotions, they did make "coaching" contributions to the discussion of their own emotions. Consider the example below.

> Resident: "Yeah. All right, next one. If they [challenges or frustrations] do become a problem during your visit what will you do? First thing is,

> um, try to work out the problem. And then the next one is like call [RTC], like we had last time."
>
> Therapist: "M'hm."
>
> Father: "Yep. I think you handled things very well last time when we had the issue, [Resident]."
>
> Resident: "Yep."
>
> Father: "And said, 'Hey, let me just cool off for a second and we'll come back and talk about this. We'd never done that with you before and we'd never had the opportunity and it worked really good. My hat's off to you and I think I told you that…"
>
> Resident: "Yep."
>
> Father: "… thought you handled it right."
>
> Resident: "And that goes along with trying to work out the problem. If there's like a thirty minute to an hour where we need to step apart from each other…"
>
> Father: "Yep."
>
> Resident: "… I still think that's trying to work out the problem and we'll come and address it when the time is needed, when we're both cooled down."
>
> Father: "Yep."

The resident helps his parents to understand how he would like to be interacted with when he experiences/expresses Anger. Instances like this were fairly common and although they do not fit with the typical mold of coaching described above, they seem like important moments for these adolescents. Rendering their opinions on emotion and emotional expression seems to offer one avenue for the renegotiation of the relationship between adolescent residents and their parents.

The findings discussed above offer a relatively clear response to Research Questions 4, 6 and 6(a). There are differences in mothers, fathers, residents, and therapist MEBs. It appears that parents and therapists MEBs do not vary based on therapeutic phase, and, it appears that both therapists and parents coach more than they dismiss. Therapists coach almost exclusively and without regard to emotion. Parents, on the other hand, were more likely to dismiss Sadness, and fathers in particular were likely to dismiss both Sadness and Anger. Residents were almost exclusively the source of emotion and the target of MEBs, including their own. With this understanding of profile of MEB, I turn now to the general discussion of these findings and their implications in Chapter V.

CHAPTER VI

GENERAL DISCUSSION

Existing research indicates that emotional education is an ongoing process that begins in childhood and extends well into adulthood (Labouvie-Vief, Devoe & Bulka 1989, Lerner, 1982, Saarni, 1999). Data also suggest that for most people, this process is relatively smooth and allows for generally competent interactions on a day-to-day basis (Arnett, 1999). For a significant segment of our society however, the process is "stormy" at best and, at its worst leaves individuals bereft of emotion-related skill and interaction-based competence. An aim of this dissertation has been to consider the problem of emotional (re)education as it occurs during family therapy sessions. More broadly, I have tried to shed light on the basic patterns of interaction that produce and/or reveal what Gottman et al. (1996) call meta-emotion philosophies.

I consider this work an initial step in a much larger program of research for an audience of scholars, practitioners, and parties interested in the interpersonal processes of emotion socialization and emotion regulation. To say that this is an initial step is not to diminish the contributions made, but rather to spur on exploration (Stebbins, 2001). The findings I have described in the preceding chapters and the implications I will discuss below make important extensions to our current understanding of Emotion Regulation Theory (ERT) (Gottman, Katz & Hooven, 1996; 1997). Ultimately, however, I believe this work will be judged by its heuristic value.

The research presented here was guided in large part by calls for theoretical extensions made more than a decade ago by the scholars who proposed ERT (Gottman et al., 1996) and those who offered helpful critiques (Eisenberg, 1996). The research questions proposed in this investigation promised to attend to communicative behavior, to address the limitations of ERT, and to illuminate issues specific to the context of residential treatment and family therapy. These same issues, along with a discussion of this investigation's limitations and directions for future research, will serve as the outline for the general discussion in this final chapter. I begin with the contributions specific to Emotion Regulation Theory.

Testing and Extending Emotion Regulation Theory

To move beyond the initial conceptualization of ERT researchers, Gottman et al. (1996) called for work that was naturalistic, tested temporal stability, incorporated a wider spectrum of emotion, accounted for children's philosophical commitments, and clarified the links between emotion philosophy and actual behavior (Eisenberg, 1996). This investigation addressed each of these concerns to varying degrees, and each will be responded to below. I begin by addressing the issue of naturalistic work and its focus on communicative behavior.

The Call for Naturalistic Research

In their seminal article, Gottman et al. (1996) argued that naturalistic samples were needed to "…see how emotion-coaching families actually talk to their children during times of heightened emotion" (p. 263). Before the Eisenberg (1996) critique

regarding the distinction between philosophy and behavior was even levied, there seems to have been some recognition of the theory's limitations. ERT is derived from interview data asking parents how they have responded to their children's expressions of emotion (i.e., Anger or Sadness) in the past, so although researchers asked about emotion in interaction, they had not observed it actually happening. The subsequent body of literature produced primarily by Katz and colleagues (Katz & Gottman, 1997; Katz & Hunter, 2007; Katz & Windecker-Nelson, 2004; Yap, Allen, Leve, Katz, 2008) has been limited to laboratory settings in which mothers and their children engage in artificial tasks while the researchers measured behaviors akin to support-giving, scaffolding, and/or derogation. Each method approximates but does not ground itself in interaction so that there is a clear sense of how coaching or dismissing "gets done."

Naturalistic Data and Testing Emotion Regulation Theory

On a very basic but practical level, this investigation's incorporation of naturalistic data tests ERT by simply asking the question: do communicative responses to emotion mirror the descriptions of coaching and dismissing philosophies? The simple answer to that question, grounded entirely in the discussion and expression of emotion during family therapy sessions is "yes." The great advantage of this work is, of course, that it provides a window to the actual enactment of these communicative processes and allows for analysis on a turn-by-turn basis. This investigation resulted in a level of description of Meta-Emotion Behaviors (MEBs) not available in the extant literature.

As I have suggested throughout Chapters IV and V, in the course of these recorded interactions, MEBs were offered in response to both situated expressions of

emotion and the discussion of past or hypothetical future emotions. A turn towards naturalistic, *in situ* observations does not exclude the discussion of emotions not being experienced in the moment. In fact, at least in this investigation, it appears that participants used stories and analogies to demonstrate understanding and by extension acceptance of emotion: important components of coaching behavior.

While it might be tempting to attribute these findings to the therapeutic context,[21] we should also consider that, more broadly, the situated expression of an emotion is likely to bring about the discussion of similar experiences through reminiscing or projecting. Recall from the review of literature that Pasupathi (2003) found storytelling to be related to the development of emotion regulation skills. It seems reasonable to suggest that storytelling is an important part of coaching behavior even for those outside therapeutic settings.

The data in this investigation also revealed four overlapping components of coaching behavior and their communicative manifestations. We can describe coaching behavior as that which demonstrates awareness, acceptance, listening, and advice giving. On the other hand, we can describe dismissive behavior as that which fails to demonstrate one or more of these "coaching" components.

We know that coaching and dismissing behavior work primarily at the relational level of the message (Watzlawick, Beavin & Jackson, 1967) in that it carries information about the relationship between the interaction partners. Coaching messages value emotion as an experiential understanding useful in its ability to help us attend to things

[21] In other words, therapy is often considered a context where it is common to delve into past experiences.

that matter. Coaching speech turns inform relational partners that their emotions can be trusted, that their experiences are valid, and that their expressions fit or do not fit with accepted guidelines for behavior. Dismissive turns suggest to relational partners that their emotional experience and/or expression have little or no value or validity in the eyes of the listener/responder. All of this fits with the existing descriptions of meta-emotion philosophy. More interesting and perhaps more importantly, this investigation also contributes descriptions of Meta-Emotion Behavior that were relatively unexpected.

Naturalistic Data and Extending Emotion Regulation Theory

Descriptions of the recorded interactions allow for important extensions of ERT. The discussion in Chapter V introduced data which solidified the importance of asking questions, providing "qualified" advice, and viewing coaching as confrontational, often implicit and skill-focused. These descriptors were each reflected in the communicative behavior of the participants, and each carries with it implications and guidance for the strategic use of MEBs. Importantly, the guidance is accessible to the general public and not limited to the domain of professionals (e.g., therapists).

The use of probing and follow-up questions was a pervasive theme in speech turns and sequences that were categorized as coaching. Questions, I have suggested, offer a microcosm of Ginot's new code of communication in that they make room for the development and demonstration of understanding emotional experience from the perspective of the source. As simple as it may seem, asking others how they feel sends a powerful relational message. It suggests to our relational others that they are viewed as competent interaction partners capable of defining their experience. I argue that this level

of recognition takes on special importance in the adolescent-parent relationship. The ability to demonstrate ownership of emotional experience is one way that adolescents can lay claim to an individuated identity. This makes emotion regulation at least one part of that process.

Questions spill into every component of coaching behavior including advice giving. The goal of a "coach" in any forum is to aid others in developing skills so that they can ultimately perform their particular skill effectively on their own. The goal is no different when it comes to emotion coaching. One way to aid in that process is to ask people who are experiencing emotion how they will go about regulating their experience and expression of emotion. The data in this investigation suggest that these questions can be offered rather bluntly or, in many cases, offered more indirectly as leading questions (e.g., Are there other ways you could express your anger?). In either case, these questions ask the source of the experience to begin to interrogate his or her personal repertoire of regulation skills which, over time, can develop into a general approach to that emotion across contexts and interactions. In answering questions, people experiencing emotion develop their ability to negotiate emotional experience for themselves.

Beyond helping others become self-efficacious, questions help to ensure that the advice giver is viewed as "qualified" to inform or advise. The cornerstone of Ginot's new code of communication is, of course, understanding must precede advice. Essentially, understanding is a demonstration of the speaker's *ethos* or credibility. A contribution this investigation makes is in offering clarity about how "understanding" and credibility or "qualification" can be demonstrated in conversation.

Questions do this. Asking questions allows the potential advice giver to gather the information necessary to understand and by extension to inform, but, "qualified" advice is more than demonstrating understanding. It also includes making room for others' opinions and possibly modifying our previously held beliefs. A speaker's credibility can be dashed by an unwillingness to admit the existence of alternate opinions, solutions, or explanations. Questions and qualifications can allow for modifications of understanding too (e.g., So, correct me if I'm wrong, are you saying…?). Qualifications like "correct me if I'm wrong," "Does that make sense?," or "In my opinion" limit the implicit scope of the statements that precede or follow them. In effect, they leave room for potential alternative opinions, solutions or explanations. These simple segments of speech turns can make all the difference at the relational level of the message.

In addition, instances of coaching in this investigation could be relationally described as confrontational, implicit, and/or skill focused. When it comes to practical application of these findings, one of the most important points to make is that coaching and dismissing messages may not sound very different from one another on the surface. The evidence provided in Chapter V suggests that coaching can be rather confrontational and that dismissing can be supportive, even cheerful. It is important to note that confrontational should not be taken to mean disrespectful but that it means engaging rather than avoiding or challenging rather than feeling comfortable. Coaching appears to work within a frame of problem-solving that may not sound altogether warm.

Those looking to employ coaching behaviors when responding to emotion should attend to the implications of their messages for skill development rather than to the

emotional tone. That is to say, what ultimately seems to set coaching responses apart from dismissive ones is that they "coach" a skill. A weakness or limitation in thinking about or acting on emotion is identified, and possibilities for addressing those concerns are explored. The data suggested two important themes in this regard.

First, the skills addressed across the recorded sessions can be likened to the most basic skills of emotional competence outlined by Saarni (1999). Coaching messages were very often directed toward the identification of an emotion, the differentiation between experience and expression, demonstrations of empathy, and developing techniques for coping with or regulating emotion. The literature suggests that attention to skills as simple as raising emotional awareness or improving emotion vocabulary can offer dividends among the more advanced skills of emotional competence such as relational awareness. This is an important implication for those who are only beginning to test the waters of this interaction style. Coaching, even in its simplest forms, can be beneficial.

The second noteworthy theme is that advice giving and skill development were typically offered implicitly. Coaching speech turns did not begin with pronouncements that it was time to build skill X. Therapists, for example, did not say to residents "I'm going to teach you how to be more aware now." Rather, a turn dedicated to coaching emotional awareness might simply ask: "How do you think you will feel when you see your friends who still use marijuana?" Again, with regard to the practical application of these findings, it seems important to be cautious about overzealous attempts to coach. Overly explicit directives may come across as disingenuous, even condescending.

Taken together, these findings based in naturalistic data provided a way to test and extend ERT. We now have concrete exemplars of coaching and dismissing behavior that are grounded in interaction, and, while the expansion of our theoretical understanding is important, it is exciting to note that this work also stands to advance practice. In addition to answering the call for naturalistic research, this investigation provides inroads to testing the temporal stability of meta-emotion philosophy by tracking the MEBs of participants in residential treatment across the four phases of intervention.

The Call for Tests of Stability

In their initial call for tests of stability, Gottman et al. (1996) were concerned with changes over time in coaching and dismissing philosophy. One implication is that these researchers were interested in the "coachability" of coaching. The context of this investigation lends itself to observation of that particular phenomenon if we assume that parents and residents in particular are engaged or enrolled at the RTC to change a host of behaviors. To date there have been no published longitudinal or cross-sectional investigations of meta-emotion philosophy. As such, the design of this investigation is an important contribution to the literature on ERT. Although the findings in this investigation remain tentative, at the very least, they call for continued research. It is also important to note that stability can and should be considered according to emotion as well. Evidence from this investigation suggests that Meta-Emotion Behavior may differ based on the emotion being responded to. I begin with the issue of temporal stability.

Temporal Stability

Evidence provided at the conclusion of Chapter V indicates relative stability of therapist and parent MEBs at each phase of intervention. Therapists almost exclusively coached regardless of family, phase, or emotion. The finding fits with their role and training as interventionists. Mother and father responses to emotion, on the other hand, were more equally divided between coaching and dismissing. At each phase, approximately 60% of the responses offered by both mothers and fathers were coaching. Gottman (1997) argues that coaching need not be the exclusive mode of interacting emotionally to reap the benefits that ERT promises (e.g., higher academic performance, positive peer and familial relationships, and improved general well-being). Rather the dominant mode of interaction (if the preponderance of responses to emotion are coaching) is what matters. Because these families are enrolled in therapeutic intervention at a residential treatment center where poor academic performance, peer and familial relationships, and poor general well-being are typically reported as antecedent conditions, it seems possible that the 60/40 proportions of coaching and dismissing behavior are not adequate to meet the "preponderance" requirement.

The observed behavior of the adolescent resident participants was less indicative of stability. Residents who participated in the Explore phase session responded to emotion with a dismissive message 80% of the time. Resident participants in the Apply and Impact phase sessions dismissed emotions 57% of the time. Importantly, residents recorded during the test phase sessions coached emotions 75% of the time. The frequency of responses is low and significantly limits the generalizability of these findings even

within the limited population of the RTC. The apparent shift in proportions of coaching and dismissing behavior according to phase of intervention, however, compels further attention. If these results are accurate, they suggest that, indeed, coaching is coachable.

These results also suggest some important relational implications perhaps specific to the context. The apparent lack of change in therapist behavior can be explained, as suggested above, by the therapists' training and role as interventionists. The apparent consistency of parent behavior, on the other hand, may suggest that they did not view themselves or their behavior as problematic components of the family system. Parents may not have felt the necessity to change their MEB. In Chapter V, I reported that therapists seemed to focus their attention on residents rather than on parents, a choice that may have reinforced the assumption that parents required little or no change. One of the potential benefits of the implicit quality in coaching is that whereas a response may be directed toward a particular member of a group, the remaining members are witness to and indirect recipients of that same message. The results here would suggest, however, that this "ripple effect" was not enough to induce a change in MEB among the parents who participated in this study.

This puts the focus squarely on the resident. An inference I make here, anecdotally, is that in some cases the coaching that occurs during these family therapy sessions tends to be specific to negotiating emotion with the resident's parents rather than toward some general societal expectation. It seems, in some instances, that the therapist's focus is on preparing the resident for the more immediate reality of returning to the family unit. In any case, there appear to be fairly defined roles within these therapy

sessions that set limits on who the source and target of MEBs are. Issues of authority, independence, and autonomy, of course, complicate these roles. For now, I turn to a discussion of the topical stability of MEBs.

Emotion Based Stability

A staple of the extant ERT research is that although parents, are asked about both Anger and Sadness, reports of emotion coaching are based on overall awareness and acceptance. Emotion coaching researchers ask and measure responses to the questions, "Are you aware of anger and/or sadness?" and "Do you accept anger and/or sadness?" The research assumes an overarching philosophy that applies to all "emotions."

Results from this investigation, however, suggest that this assumption may be an oversimplification. For example, mothers in this investigation coached every emotion tracked except Sadness. In fact, the greatest disparity in mothers' MEBs was between Anger and Sadness. If philosophy and interaction are not independent of one another, as Gottman et al. (1996) suggest, and the results of this investigation can be verified, then failing to differentiate between separate emotions in the measurement of meta-emotion philosophy may be problematic. It may be more accurate to base assessments of philosophy and behavior according to specific emotions.

As a test of ERT, these findings pinpoint a potential limitation. As an extension, these findings open up a variety of possibilities for future research and complicate our understanding of emotion regulation. In light of these findings, I turn now to a discussion of how this investigation answered the call for incorporating emotions other than Anger, Sadness, and Fear in the measurement of meta-emotion philosophy.

The Call for Expanding the Emotional Spectrum

As suggested above, when the call for expanding the spectrum of emotions included in the measurement of meta-emotion philosophy was made, it was not meant to address the issue of stability. Rather it was meant to help assess an overarching conception of "emotion." The naturalistic and interaction-based approach taken in this investigation framed emotion expansion as a much more grounded issue. I asked what emotions are present/salient in these interactions and how they are responded to. These questions work from the perspective that coaching and dismissing philosophy might be more contextually based than has been proposed by ERT.

As reported in Chapter IV, this investigation incorporated grounded emotion terms that were collapsed into the prototype categories proposed by (Shaver, Schwartz, Kirson & O'Connor, 1987). Evidence suggests that although Anger and Sadness were present and salient emotions in this context, researchers should also attend to the expression and discussion of Fear, Love and Joy. Beyond simply expanding the emotions included in the study of MEB, we must also take into consideration the possibility that people develop separate meta-emotion philosophies for different categories or prototypes of emotion.

The Call for Including Children

Attending to the adolescent residents' MEBs offers an extension to ERT on two levels. First, it answers the call for assessing children's meta-emotion philosophies which no published study has done to date. Second, it pushes ERT toward the adolescent developmental phase, which only a handful of studies have done. For the most part,

researchers have treated the children involved in these studies as passive recipients or blank slates waiting to have an emotion philosophy written upon them. Bringing a communicative perspective to this investigation has meant viewing the adolescent residents who participated in this study as interaction partners with their parents and therapists. I have argued in this and previous chapters that one way adolescents begin to develop an individuated identity is to render opinions about their own and their relational partners' emotions. The evidence suggests that, on a relational level, coaching responses to these expressions can reinforce the idea that the adolescent is viewed as a legitimate conversational partner and aids in the process of individuation.

In Chapter V, I reported on the tendency of the resident participants to offer opinions about their own emotions and their simultaneous reluctance to respond to their parents. One apparent exception to this rule was the willingness of residents to describe to their parents guidelines for interaction in the event that they were experiencing an emotion (e.g., "When I'm angry, I just need some time to cool down before we talk about it").

Their general reluctance to respond to their parents seems likely to be bound by assumed rules regarding their role within the context of the therapy session. Freed from this context and engaged in a different role (e.g., peer), these residents might be more likely or at least prepared[22] to respond to emotion. The implication is that coaching behavior may not only shift with emotion but also by contextual rules and roles.

[22] In their explication or ERT, Gottman, Katz and Hooven (1997) argued that what children gain from being coached is an ability to regulate their own emotion rather than a transferable set of social skills. In fact, they suggest that coaching behavior enacted among a peer group would draw unwanted attention

This investigation's response to the calls for expanding ERT has uncovered new and more complex ways to think about emotion coaching. The research findings have both tested and expanded existing theoretical conceptualizations. A second important purpose of this dissertation has been to offer practical contributions to both the RTC specifically and to practitioners in general. The next section outlines those contributions.

Contributions to the RTC

In addition to the research questions specific to ERT, I asked questions aimed at developing a better understanding of the context of family therapy. In particular I asked which therapeutic tasks were most salient across the phases of intervention at the RTC. For the purpose of making my findings accessible to both the clients of and practitioners at the RTC, I chose to use the therapeutic task vernaculars outlined in the RTC Employee Handbook (Balmer, 2005). Results indicated that the existing task vernaculars offered only minimal utility. A vast majority of coded tasks were written in under the generic therapeutic tasks: Low Self-Image, Inconsiderate of Self, and Inconsiderate of Others. Comparative analyses allowed for the identification of "new" specific task vernaculars that may be useful to the RTC. Each is described briefly in Table 16.

These proposed new task vernaculars offer a level of specificity about the "issues" or "problems" the participants in this investigation were focused on during their therapy sessions. The low frequencies observed in the original task categories and the relative

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during middle-childhood. But, as the demands of their roles begin to shift with adolescence it may become increasingly important for adolescent children to coach. Moreover, I would argue that coaching behavior is less conspicuous in actual interaction than what these authors are suggesting

Table 16 *Grounded Task Vernaculars*

Tasks	Descriptions
Advocating for Self	This task was indicated when the resident undermined his general self interests including engagement in therapy and expression of future goals.
Social Skill	This task was indicated when discussing apparent social ineptitudes including rudeness, social norms, and guidelines for roles.
Education	This task was indicated when participants discussed past, present, and future academic activities.
Thinking Errors	This task was indicated by a wide variety of thought patterns that were either inaccurate or exaggerated including black and white thinking and minimizing
Emotion Regulation	This task was indicated by the discussion of appropriate expressions of appropriate emotion including coping skills, processing, and problem solving.
Family Dynamics	This task was indicated by the discussion of conflict specific to the family, renegotiation of roles within the family and changing patterns of interaction within the family.

frequency with which the above tasks were observed indicate the need for reevaluation of the original vernaculars. Specific and accurate vernaculars provide clear guidelines for understanding one another and suggest the appropriate framework for therapeutic intervention. Although these vernaculars are specific to the RTC, it seems likely that they have extended relevance more broadly in family therapy.

In addition to the suggested updates to task vernaculars, other issues arose relevant to the practice of intervention at the RTC. The first of these issues concerns the approach to discussing emotion and rationality. In Chapter V, I provided an example that seems to clarify the relationship in a way that preserves the utility of emotion. In most cases, however, participant comparisons of emotion and rationality left emotion cast as irrational. It seems prudent to suggest that attention to the relationship between emotion and rationality would serve to facilitate discussions of emotion regulation. The second issue has to do with evidence that suggests there are differences in the emotion profiles comparing the two lower phases of intervention with two upper ones. Evidence also suggests that the patterns of MEBs are different at the lower and upper phases. Although more research is needed, it may ultimately be possible to determine therapeutic progress by tracking MEB.

Concluding Remarks

I began this investigation with one foot in the world of practice and one foot in the world of theory. My professional and academic pursuits overlapped and informed one another. My hope is that this dual grounding is apparent in the writing and makes the work accessible to an audience of both scholars and practitioners. In addition, while I

believe this work to be useful to the RTC, I also believe many of the findings will be valuable for parents and their children within the more general context of family therapy. Still more broadly, these findings can be useful to "healthy" families whose tensions and difficulties may differ in scale but are similar in form and content to the struggles of those families who need help.

Many of the contributions made in this investigation are founded in communicative behaviors as they occurred naturally during these therapy sessions. This naturalistic approach was, in part, a response to the call from Gottman et al. (1996), but it also reflects a personal commitment to interaction-based scholarship. The results presented above and in the preceding chapters clarify the character of Meta-Emotion Behavior, call into question the emotion-based stability of meta-emotion philosophy, suggest that emotion regulation plays an important role in family therapy, and incorporate adolescent children as relational partners in the discussion of emotion. This work has, as promised in the introduction and rationale for this study, pushed the boundaries of Emotion Regulation Theory. In some ways, the inferences made in this investigation complicate our understanding of meta-emotion philosophy and behavior, but these findings also help to make this theory more practically applicable.

This work is, like all other research endeavors, not without its limitations. The unequal distribution and limited number of participants constrain the generalizability and/or robustness of the findings. The absence of female residents is particularly limiting especially in light of results and research that suggest there may be gender differences. The sample is not diverse with regard to ethnicity or socio-economic status. Therapists

included in this investigation were all White males between the ages of 28 and 42. The cross-section design is only an indirect measure of temporal stability, and, although the prototype categories of emotion facilitated the expansion of the emotion spectrum, it also "fixed" categories where it might have been more informative to remain fluid or situated. Ultimately it is possible to overcome or minimize these limitations in future research.

In addition to a general call for a more diverse sample (i.e., ethnicity, gender, socio-economic status) and longitudinal work (i.e., tracking a family from admittance to graduation), I suggest the following more specific lines for future research. Anecdotal evidence suggests that there may be a place for the strategic use of dismissive messages in the course of therapeutic intervention. If laissez-faire types of responses can offer a sense of extended acceptance and facilitate the establishment of rapport between a therapist or interventionist and his or her client, such responses might be useful. A second specific avenue for future research could be the exploration of more direct coaching for parents engaged in family therapy. In this investigation, it appeared that the resident was the primary focus of "family" therapy. Although the issue of coaching parents in the presence of their children may evoke the complexities of authority in the parent-child relationship, it seems counter-intuitive to a systemic view of family interaction to implicitly frame the child as the "problem." Finally, as suggested above, it may be appropriate to re-evaluate the utility of the prototype model in future research. "The prototypical categories of emotion, as defined by linguistic meaning, may not be the most useful categories for investigating MEPs. For example, within the Shaver et al. (1987) categories, shame and guilt are lumped together in the Sadness prototype. While this may

be an accurate categorization, the subtext or relational value of shame and guilt are quite different from Sadness. The collapse of these emotions may be too limiting when, as it appears in this investigation, people develop emotion-specific philosophies.

In sum, I argued that undertaking this investigation from a communicative perspective and using a naturalistic methodology would allow me to focus a "light" on areas of Emotion Regulation Theory that were previously left in the dark. I believe that has been the case. I have been able to provide a focused description of the quality and character of coaching behavior among the participants engaged with this RTC, and I have been able to do so in a way that I believe can and will resonate with their lived experience. I view the therapeutic process as about change. My hope is that this study moves both scholars and practitioners toward the changes we need to assist those who seek intervention.

APPENDIX A

DEMOGRAPHIC QUESTIONS FOR ALL PARTICIPANTS

AGE: _____ SEX (please circle one): Female / Male

RACE/ETHNICITY (please circle one):

American Indian or Alaska Native

Asian or Pacific Islander

Black or African American Black, non-Hispanic

White, non-Hispanic

Hispanic

APPENDIX B

DEMOGRAPHIC QUESTIONS FOR RESIDENTS

How long have you been enrolled at IV RTC ? (in months, days or weeks):

_____

If IV is not your first program, how long have you been enrolled in any intervention programs? (in years, months, weeks, or days): _____

What is your current IV RTC phase? (please circle one):

Explore Apply Impact Test

APPENDIX C

DEMOGRAPHIC QUESTIONS FOR PARENTS

MARITAL STATUS (Please circle one):

Single Married Separated Divorced Re-married

Other_____

PARENTAL STATUS with regard to IV resident (Please circle one):

Birth Step-parent Adoptive

How long (in years, months or weeks) has your family been engaged in therapy?

_____

APPENDIX D

DEMOGRAPHIC QUESTIONS FOR THERAPISTS

How long (in years, months or weeks) have you practiced in field of social work?

_____

How long (in years, months, or weeks) have you practiced at IV RTC?

_____

How long have you worked with the participating family (in months or days)?

_____

How many cases do you currently carry at IV RTC? _____

How typical is this family for this phase (Please circle one)?

Very Typical	Somewhat Typical	Neutral	Somewhat Atypical	Very Atypical
5	4	3	2	1

APPENDIX E

EMOTION EPISODE CONTENT ANALYTIC CODE SHEET

Episode #
Phase: Explore Apply Impact Test

Emotion: Love Joy Surprise Anger

Sadness Fear Double (a)_____

Other_____ (b)_____

Source: Resident Male Resident Female Therapist

Father Mother Sibling

Resident Peer Home Peer RTC Staff

Parents Other_____

Target: Resident Male Resident Female Therapist

Father Mother Sibling

Resident Peer Home Peer RTC Staff

RTC Situation Home Situation Parents

Other_____

Task: **Specific**

Authority Problems Misleads Others Easily Misled

Aggravates Others Easily Angered Stealing

Alcohol or Drugs Lying Fronting

General

Low Self Image Inconsiderate of Others Inconsiderate of Self

Other_____

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